

PROVIDING BREASTFEEDING SUPPORT: MODEL HOSPITAL POLICY RECOMMENDATIONS

Update: June, 1999



**THE BREASTFEEDING COALITION OF THE
INLAND EMPIRE
&
INLAND COUNTIES REGIONAL PERINATAL PROGRAM**

PROVIDING BREASTFEEDING SUPPORT: MODEL HOSPITAL POLICY RECOMMENDATIONS

Update: June, 1999

ADAPTED FROM:

ST. JOSEPH MEDICAL CENTER
THE FAMILY BIRTHPLACE
BREASTFEEDING EDUCATIONAL PROTOCOL
BELLINGHAM, WASHINGTON

WELLSTART INTERNATIONAL
LACTATION MANAGEMENT EDUCATION PROGRAM
SAN DIEGO, CALIFORNIA

SUPPORTED BY:

BREASTFEEDING COALITION OF THE INLAND EMPIRE
CALIFORNIA STATE LICENSING AND CERTIFICATION
CALIFORNIA STATEWIDE COMMITTEE ON BREASTFEEDING PROMOTION
STATE OF CALIFORNIA MATERNAL AND CHILD HEALTH BRANCH
WELLSTART INTERNATIONAL

COVER LOGO:

SAN BERNARDINO COUNTY WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM

Inland Counties Regional Perinatal Programs is partially funded by a grant from the State of California,
Department of Health Services, Maternal and Child Health Branch.

Model Policy Committee

Lila Bergman, RN, CLE, CLC, Maternity Staff Nurse
Kaiser Permanente Medical Center

Elizabeth Creer, RN, FNP, MPH, Family Nurse Practitioner
Wellstart International

Amy Gonzalez, RN, CLC, Parent Educator
St. Bernardine Medical Center

Suzanne Haydu, MPH, RD, Maternal and Child Health Branch
State of California Department of Health Services

Joyce Heitmeier, RNC, Perinatal Clinical Nurse Specialist
Community Hospital of San Bernardino

Chairperson, Carolyn Lopez Melcher, RNC, MPH, CLE
Regional Perinatal Program Coordinator
Loma Linda University Children's Hospital

Pat Spier, RNC, BSN, Perinatal Nurse Manager
San Bernardino County Medical Center

Marlene Steinweg, MPH, Health Educator
San Bernardino County Public Health Department

Aida Rodriguez, NNP, Neonatal Nurse Practitioner
San Bernardino County Medical Center

Model Policy Revision Committee

Gretchen Andrews, BA, IBCLC, The Lactation Connection
Inland Midwife Services

Debbie Edwards, RN, IBCLC,
Rancho Springs Medical Center, Murrieta

Donna E. Erlewine, MSN, CLE, Lactation Coordinator
Loma Linda University Children's Hospital

Penny Gibbs, PNP, CLC, Pediatric Clinic
Kaiser Permanente Medical Center, Fontana

Laurie Haessly, MA, RD, IBCLC,
Women, Infants and Children Program (WIC)
County of Riverside, Department of Public Health, WIC Program

Mary Anna Heywood, RN, CPSP Manager
Redlands Community Hospital

Chairperson, Carolyn Lopez Melcher, RNC, MPH, CLE
Regional Perinatal Program Coordinator
Loma Linda University Children's Hospital

Kathleen O'Connell, LVN
Hollister Incorporated

Raylene Phillips, MA, CLC
Infant Development, Lactation Consultant

Aida Rodriguez, NNP, Neonatal Nurse Practitioner
Arrowhead Regional Medical Center

Sue Schaul, RN, BHS, Perinatal Nurse Manager
Moreno Valley Community Hospital

Marlene Steinweg, MPH, Health Educator
San Bernardino County Public Health Department

Debbie Tweedy-Wolfe, RN, CLE, IBCLC
John F. Kennedy Memorial Hospital, Indio

Nancy Wolfe, RN, BS, Inland Counties Regional Perinatal Program
Loma Linda University Children's Hospital

Jeri Zevenbergen, MPH, RD, CLE, Breastfeeding Coordinator
San Bernardino County, Department of Public Health, WIC Program

A Special Thanks to:

Kay Dewey, PhD, Professor, Department of Nutrition
University of California, Davis

Suzanne Haydu, MPH, RD, Maternal and Child Health Branch
State of California Department of Health Services

Kathleen Huggins, RN, MS

Chele Marmet, BS, MA, IBCLC
The Lactation Institute, Los Angeles

Audrey Naylor, MD
Wellstart International, San Diego

Laurie Pennings, MS, RD
California Women, Infants and Children Supplemental Nutrition Branch

Debbie Pierce, RN, IBCLC
Butte County Public Health

Jan Porter, RD, MPH
California Women, Infants and Children Supplemental Nutrition Branch

Marilyn Schuster, California Children Services
San Luis Obispo County Public Health Department

Bruce Smith, MD, MPH, Maternal, Child and Adolescent Health Medical Officer
San Bernardino County Department of Public Health

Patty Pasquarella, MS, RD, Licensing and Certification Division
State of California Department of Health Services

Word processing, formatting and reproducing provided by:

The Inland Counties Regional Perinatal Programs

Editing provided by:

Health Net, Provider Communications Department
Carolyn Beth Smith, MLISc

TABLE OF CONTENTS

Introduction.....	1
Recommendations for Successful Development & Implementation	2
Summary of Model Hospital Policies	3
Expanded Hospital Policies and References	5
Policy # 1	5
Policy # 2	8
Policy # 3	11
Policy # 4	13
Policy # 5	19
Policy # 6	22
Policy # 7	25
Policy # 8	28
Policy # 9	30
Policy # 10	32
Policy # 11	35
Policy # 12	37
Appendix I: UNICEF Hospital Self Appraisal Tool	
Appendix II: Acceptable Medical Reasons for Supplementation Sample Consent to Supplement Newborn Infants Sample Insurance Letter	
Appendix III: American Academy of Pediatrics Policy Statement	
Appendix IV: Resources Regional Breastfeeding Coalitions in California	

INTRODUCTION

There is overwhelming scientific evidence that breastmilk is the optimal food for infants. Numerous professional organizations actively encourage breastfeeding including the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Hospital Association, the Association of Women's Health, Obstetrics and Neonatal Nurses and the American Dietetic Association.

This document was originally compiled by a local coalition as an exercise in the development of breastfeeding policies based on scientific data. They are shared to assist and support hospital systems in their efforts to replicate this process and better support breastfeeding. Because most babies are born in the hospital, there is a clear opportunity for hospital personnel to affect the initiation of breastfeeding as well as the education and support of breastfeeding mother/infant pairs, which will increase the duration of this health enhancing, cost saving practice.

These model policies are intended to be used as a framework that should be molded to fit each particular setting. This should be done through a review of the literature by local committees who will implement the resulting policies. These recommendations apply to normal, full-term infants and are not intended to apply to the specific needs of high-risk infants.

We welcome your feedback and suggestions and wish you well in your efforts to offer the best support for mothers and infants.

Carolyn Lopez Melcher, RNC, MPH, CLE
Regional Perinatal Program Coordinator

**RECOMMENDATIONS FOR SUCCESSFUL DEVELOPMENT
AND
IMPLEMENTATION OF HOSPITAL POLICIES ON BREASTFEEDING**

1. Create an interdisciplinary team to review and strengthen breastfeeding policies. This team should include members who:
 - a. support breastfeeding
 - b. understand the breastfeeding process
 - c. represent the cultures of the community they serve.
2. Revise hospital breastfeeding policies as they come up for review.
3. Review the literature prior to making recommendations to the hospital policy committee.
4. Recognize that these policy recommendations are intended to be a guide and should be adapted to fit your hospital's needs. The Breastfeeding Coalition of the Inland Empire has made broad recommendations that may not fit every situation.
5. Implementation of new or revised policies should be accompanied by staff education, patient education materials and ongoing support and reinforcement of the new policies.

Breastfeeding Coalition of the Inland Empire

SUMMARY OF MODEL HOSPITAL POLICIES

PURPOSE:

These model policies are designed to give basic information and guidance to perinatal professionals wishing to revise policies that affect the breastfeeding mother. The rationale and references are included as education for those unfamiliar with current breastfeeding recommendations. When no reference was available, the interventions noted are considered to be best practice as determined by consensus of the Breastfeeding Coalition of the Inland Empire.

Policy #1:

Establish a strategy that promotes and supports breastfeeding through formation of an interdisciplinary, culturally appropriate team comprised of hospital administrators, medical staff, nursing staff, a lactation specialist/consultant and nutrition staff. The team should seek information and advice from local experts and patients using the services. Technical assistance from a community lactation expert can be used to support this process. This team will be responsible for:

- implementing hospital policies
- ensuring training of all staff
- providing ongoing education
- performing an evaluation based on guidelines similar to the *Baby-Friendly Hospital Initiative Guidelines and Criteria*

Policy #2:

All pregnant women will receive information, prior to birth, following birth, and before discharge regarding the benefits and management of breastfeeding. This information will include how to maintain lactation when separated from their infants. All classes and teaching materials will be considerate of the woman's cultural background, education and language.

Policy #3:

All mothers will have documented in the obstetric chart a complete breast exam and will receive anticipatory guidance for any condition that could affect breastfeeding (for example, inverted nipples, breast pathology, or prior breast surgery).

Policy #4:

Mothers will be encouraged to exclusively breastfeed. During the hospital stay, nursing staff will perform breastfeeding evaluations and monitor the infant's urine and meconium output. All breastfeeding mothers and their newborns should be seen by a pediatrician or other knowledgeable health care practitioner 48-72 hours after discharge.

Policy #5:

Assuming that the baby and mother are stable, the mother and baby will be skin-to-skin during the first several hours following birth. This includes the post-cesarean mother and baby. The baby will be encouraged to breastfeed ad lib without restriction. Nursing policies and practices will support care of the mother and infant together.

Policy #6:

Every mother will be instructed in proper breastfeeding technique and assessed for proper latch-on at birth and at least once every 8 hours while in the hospital. When an assessment (for example, FAIB or LATCH) identifies a dysfunction or the infant displays signs of inadequate intake, a lactation consultation will be ordered.

Policy #7:

Within the first 24-48 hours following birth, if feedings at the breast are incomplete, ineffective, or the mother is separated from her infant, the mother will be instructed to begin regular pumping of her breasts, with continued assistance by an experienced staff member. The colostrum or breastmilk obtained will be given to the baby unless contraindicated.

Policy #8:

Pacifiers will not be given to breastfeeding infants.

Policy #9:

Supplementary water or artificial infant milk will not be given to breastfeeding infants unless specifically ordered for a clinical condition by the physician. Maternal consent specifying the risks of introducing artificial infant milk to the newborn will be required prior to beginning artificial feeding of any infant.

Policy #10:

Infants should remain at the mother's bedside both day and night. The nurse should plan with the mother and family for periods of rest and sleep.

Policy #11:

At discharge, each mother will be referred to a breastfeeding support group and given the telephone number of a lactation specialist/consultant or community resource for breastfeeding assistance. Commercial advertising or promotional packs should not be given to any mother whether bottle-feeding or breastfeeding.

Policy # 12

Hospital administration will foster formation of breastfeeding support groups.

EXPANDED HOSPITAL POLICY #1

Establish a strategy that promotes and supports breastfeeding through formation of an interdisciplinary, culturally appropriate team comprised of hospital administrators, medical staff, nursing staff, a lactation specialist/consultant and nutrition staff. The team should seek information and advice from local experts and patients using the services. Technical assistance from a community lactation expert can be used to support this process. This team will be responsible for:

- implementing hospital policies
- ensuring training of all staff
- providing ongoing education
- performing an evaluation based on guidelines similar to the *Baby-Friendly Hospital Initiative Guidelines and Criteria*

INTERVENTION/MANAGEMENT	RATIONALE
Concerned individuals should join together to reduce institutional barriers to breastfeeding, such as mother-infant separation, fragmentation of care and routine supplementation with formula.	A multidisciplinary task force can bring a variety of perspectives and a research base to institutional breastfeeding policies. ^{2,8,9,10}
Interdisciplinary team members should be aware of the International Code of Marketing Breastmilk Substitutes.	International concern exists regarding the marketing practices of infant formula manufacturers. Accepting educational grants, teaching materials, gratuities and gifts from formula companies may indirectly endorse infant formula. ^{1, 11, 12}
A designated healthcare professional should be responsible for assessing needs, planning, implementing, evaluating and periodically updating competency-based training in breastfeeding for all staff caring for mothers, infants, and/or children.	Ongoing training is essential to maintain staff competency. The level of competency required and/or needed should be based on staff functions, responsibilities, and previously acquired training, and should include documentation that essential competencies have been mastered. ^{3,5}

INTERVENTION/MANAGEMENT	RATIONALE
All hospital departments serving mothers, infants and/or children will have written breastfeeding policies that are routinely communicated to all health care staff.	Ongoing reinforcement of policies is essential to maintaining competence. ⁴
Nurses coming in contact with mothers, infants or children will receive standardized education and training on the support and management of lactation. Lactation management will be included as part of orientation as well as included as part of ongoing training and competency evaluation for both nurses and physicians.	Training can assist nurses in using common terms and standard recommendations. Mothers are often confused and frustrated when receiving varying advice. Eighteen hours of education (15 didactic, 3 clinical) is the minimum amount of lactation training recommended by the World Health Organization. Breastfeeding management courses are available. ^{6,7}

POLICY #1

REFERENCES

1. Armstrong, H. C., & Sokol, E. (1994). The international code of marketing of breast-milk substitutes: What it means for mothers and babies world-wide. International Lactation Consultant Association.
2. Baby-Friendly USA: U.S. Baby-Friendly hospital initiative guidelines and criteria. Sandwich, MA: U.S. Committee for UNICEF/Wellstart International, March 1996; entire document.
3. Ellis, D. J. (1992). Supporting breastfeeding: How to implement agency change. *NAACOG's Clinical Issues in Perinatal and Women's Health Nursing*, 3, 560-564.
4. Ellis, D. J. (1992). The impact of agency policies and protocols on breastfeeding. *NAACOG's Clinical Issues in Perinatal and Women's Health Nursing*, 3, 553-559.
5. Hales, D. J. (1981). Promoting breastfeeding: Strategies for changing hospital policy. *Studies in Family Planning*, 12, 167-172.
6. Healthy Children 2000 Project funded by the United States Department of Health and Human Services, Public Health Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau. (1999). *The curriculum to support the ten steps to successful breastfeeding: An 18-hour interdisciplinary breastfeeding management course for United States*. Health Education Associates.
7. Korvach, A. C. (1997). Hospital breastfeeding policies in the Philadelphia area: A comparison with the ten steps to successful breastfeeding. *Birth*, 24(1), 41-48.
8. Mulford, C. (1995). Swimming upstream: Breastfeeding care in a nonbreastfeeding culture. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 24, 464-473.
9. Powers, N., et al. (1994). Hospital Policies: Crucial to breastfeeding success. *Seminars in Perinatology*, 18, 517-524.
10. Reiff, M. I., & Essock-Vitale, S. M. (1985). Hospital influences on early infant-feeding practices. *Pediatrics*, 76, 872-879.
11. Resolution WHA43.3 (Handbook of resolutions and decisions of the World Health Assembly and the Executive Board), Volume III, 3rd ed., Geneva, 1993.
12. World Health Organization. *International Code of Marketing of Breast-milk Substitutes*. Document WHA34/1981/REC/1, Annex 3, Geneva, 1981.

EXPANDED HOSPITAL POLICY #2

All pregnant women will receive information, prior to birth, following birth, and before discharge regarding the benefits and management of breastfeeding. This information will include how to maintain lactation when separated from their infants. All classes and teaching materials will be considerate of the woman's cultural background, education and language.

INTERVENTION/MANAGEMENT	RATIONALE
All pregnant women and their partners will be informed of and encouraged to attend a breastfeeding class during the prenatal period.	Knowledge and support improve the breastfeeding experience. Most women make their decision about breastfeeding long before delivery. ^{1,5,8,10,11,12}
Nurses caring for mothers and infants will provide appropriate education using techniques such as one-to-one teaching, group classes, pamphlets and/or video taped instruction.	Pamphlets can be used by the breastfeeding specialist and nursing staff for one-to-one patient education. This provides consistency of information given by nursing staff and provides a similar frame of reference. The mother can refer to educational materials during and after her hospital stay to reinforce learning. ^{6,9,13}
Classes, pamphlets and videos will be considerate of the woman's cultural background, education and language.	Health educators who understand the cultural and socioeconomic context of infant feeding practices of the women they serve may be able to provide clients with health education and care that is more relevant. ^{3,11}
Materials that promote the use of commercial products known to interfere with breastfeeding will not be used to teach breastfeeding.	Due to the potential conflict of interest, all materials used for breastfeeding promotion and education need to be produced by institutions and agencies dedicated primarily to promoting breastfeeding. ^{5,10}
Teaching methods will be tailored to the age of the client.	Teens may prefer alternative learning opportunities, such as field trips, games and videos when appropriate. ²

INTERVENTION/MANAGEMENT	RATIONALE
<p>Physicians are encouraged to support breastfeeding enthusiastically as recommended by the American Academy of Pediatrics guidelines and educate patients accordingly (Appendix III). Many professional organizations actively encourage breastfeeding including the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American Hospital Association, the Association of Women's Health, Obstetrics and Neonatal Nurses and the American Dietetic Association.</p>	<p>Physicians can influence their patients' health behavior choices during the perinatal period.¹²</p>
<p>All mothers should be taught hand expression of breast milk prior to discharge. All mothers need to receive information about expression and pumping for anticipated and unanticipated separation from their infants.</p>	<p>Maintaining lactation during temporary separation is critical to the comfort and health of the lactating mother. Hand expression can be used at any time and is the method of choice for occasional or unplanned separation. Information regarding pumping should be provided in an effort to give the mother resources for future planned separations (returning to work or school). Pumping should not be encouraged during the early postpartum period when the infant is effectively suckling, unless medically indicated.^{7,8}</p>

POLICY # 2

REFERENCES

1. American Academy of Pediatrics work group on breastfeeding. (1997). Breastfeeding and the use of human milk. *Pediatrics*, 100, 1035-1039.
2. Bachman, J. A. (1993). Self-described learning needs of pregnant teen participants in an innovative university/community partnership. *Maternal-Child Nursing Journal*, 21(2), 65-71.
3. Bertelsen, C., & Auerbach, K. G. (1987). Nutrition and breastfeeding: The cultural connection. *Lactation Consultant Series*. La Leche League International.
4. Frantz, K. (1994). *Breastfeeding product guide*. Sunland, CA: Geddes Productions.
5. Lawrence, R. A. (1994). *Breastfeeding: A guide for the medical profession* (4th ed.). St. Louis: C.V. Mosby.
6. Libbus, M. K. (1994). Lactation education practice and procedure: Information and support offered to economically disadvantaged women. *Journal of Community Health Nursing*, 11(1), 1-10.
7. Marmet, C. (1980, revised 1988). *Manual expression of breastmilk: Marmet technique*. Encino, CA: Lactation Institute Publications.
8. Marmet, C., & Shell, E. (1988). Instruments used in breastfeeding: A guide. In D. B. Jelliffe, & E. F. Jelliffe (Eds.), *Programmes to promote breastfeeding* (pp. 330-339). Oxford: University Press.
9. Righard, L. & Alade, M. (1990). Effect of delivery room routines on success of first breast-feed. *The Lancet*, 336, 1105-1107.
10. Riordan, J., & Auerbach, K. G. (1999). *Breastfeeding and human lactation* (2nd ed.). Sudbury, MA: Jones and Bartlett.
11. Rossiter, J. C. (1994). The effect of a culture-specific education program to promote breastfeeding among Vietnamese women in Sydney. *International Journal of Nursing Studies*, 31, 369-379.
12. Wiles, L. S. (1984). The effect of prenatal breastfeeding education on breastfeeding success and maternal perception of the infant. *JOGN Nursing*, July/August, 253-257.
13. World Health Organization, (1998). *Evidence for the ten steps to successful breastfeeding*. Geneva: World Health Organization.

EXPANDED HOSPITAL POLICY #3

All mothers will have documented in the obstetric chart a complete breast exam and will receive anticipatory guidance for any condition that could affect breastfeeding (for example, inverted nipples, breast pathology, or prior breast surgery).

INTERVENTION/MANAGEMENT	RATIONALE
<p>The provider should examine the breast to assess the following:</p> <ul style="list-style-type: none">• previous breast surgery• nipple protractility• progressive breast enlargement during pregnancy• breast pathology	<p>Providers should identify mothers with breast abnormalities prior to birth and provide appropriate anticipatory guidance.^{1,2,3,4,5}</p>

POLICY # 3

REFERENCES

1. Huggins, K. (1995). *The nursing mother's companion* (3rd ed.). (pp. 14-16). Boston: Harvard Common Press.
2. Lawrence, R. A. (1987). The management of lactation as a physiologic process. *Clinics in Perinatology*, 14, 1-10.
3. Lawrence, R. A. (1994). *Breastfeeding: A guide for the medical profession* (4th ed.). St. Louis: C.V. Mosby.
4. Marmet, C., & Shell, E. (1989). *Lactation forms: A guide to lactation consultant charting*. Encino, CA: Lactation Institute Press.
5. Powers, N. G., & Slusser, W. (1997). Breastfeeding update 2: Clinical lactation management. *Pediatrics in Review*, 18, 147-161.

EXPANDED HOSPITAL POLICY #4

Mothers will be encouraged to exclusively breastfeed. During the hospital stay, nursing staff will perform breastfeeding evaluations and monitor the infant's urine and meconium output. All breastfeeding mothers and their newborns should be seen by a pediatrician or other knowledgeable health care practitioner 48-72 hours after discharge.

INTERVENTION/MANAGEMENT	RATIONALE
Perinatal caregivers will educate the mother on the rationale for exclusive breastfeeding during the first six months.	Exclusive breastfeeding during the first six months is associated with optimal infant growth and development. ^{2,7,11,20,28} Encouraging exclusive breastfeeding during the first few weeks aids in the establishment of an adequate milk supply and appropriate breastfeeding technique. ^{13,14,15,29} The staff will be demonstrating compliance with the American Academy of Pediatrics' policy statement on breastfeeding and the Surgeon General's goal for the nation. ^{2,3,30}
All mothers will be given oral explanation and written material about specific resources for follow-up. The information will include normal breastfeeding patterns and normal output of urine and stool. If the baby varies from these normal patterns the mother should know to immediately contact her health care provider.	The newborn can suffer from dehydration, hyperbilirubinemia and electrolyte imbalances if exclusive breastfeeding does not progress normally. Mothers who are encouraged to exclusively breastfeed need support and available resources in the event that early breastfeeding complications occur. ^{5,6,9,16,25}
Mothers will be instructed to schedule a follow-up visit with their health care provider.	Exclusively breastfed newborns need a formal evaluation of breastfeeding during the first 48-72 hours after discharge. This follow-up visit should include an assessment of breastfeeding, an infant weight and a maternal interview. ^{2,30}
Nursing staff will monitor urine and meconium output during the hospital stay.	Normal newborn patterns will be recognized and appropriate follow-up will be recommended when indicated. ^{17,18}

INTERVENTION/MANAGEMENT	RATIONALE
Perinatal caregivers will educate mothers regarding the risks of early introduction of artificial infant milk and nipples.	Mothers are likely to follow recommendations given to them by perinatal professionals. Supplementation during this time will decrease the likelihood that extended breastfeeding will occur. ^{13,14,15,22,30}
Perinatal caregivers will share recent recommendations with new mothers regarding the specific risks of artificial infant milk .	<p>Families may be unaware of the risks of artificial feeding for the mother and infant. Introducing artificial infant milk:</p> <ul style="list-style-type: none"> • increases the risk of diarrhea, upper respiratory infections and otitis media^{2,11} • may not provide optimal nutritional composition for central nervous system development^{11,26,27} • may increase the risk of juvenile diabetes^{2,11,27} • may increase the risk of some allergies^{2,11,27} • may increase the risk of Sudden Infant Death Syndrome^{2,11,27} • may increase the risk of Crohn's disease, ulcerative colitis and childhood lymphomas^{2,11,27} • alters the flora of the baby's gut^{11,18} • has a longer gut transit time than breastmilk and may decrease the infant's interest in nursing.^{17,18} <p>Introducing artificial nipples:</p> <ul style="list-style-type: none"> • may prevent optimal tooth, jaw and speech development²⁷ • may encourage the infant to suck incorrectly, since on an artificial nipple the baby will be rewarded even for an incorrect suck. This is sometimes referred to as "nipple preference".^{15,22}

INTERVENTION/MANAGEMENT	RATIONALE
Perinatal caregivers will share recent recommendations with new mothers regarding the specific risks of soy formulas.	<p>Routine use of soy formulas in lieu of breastfeeding is not recommended unless there is a specific medical indication. Multiple concerns regarding soy have led the American Academy of Pediatrics to advise against the routine use of soy formulas. Specific risks of introducing soy formulas might include:</p> <ul style="list-style-type: none"> • soy is at least as allergenic as cow milk • soy is associated with a poorer response to vaccinations • soy-fed infants have a higher rate of illness^{27,28,29}
Perinatal caregivers will share recent recommendations with new mothers regarding the specific risks of early introduction of water or glucose water. Patient education should also include cautioning against the use of infant teas and electrolyte replacement fluids.	<p>Risks of early introduction of water or glucose water to the infant might include:</p> <ul style="list-style-type: none"> • glucose water with 6 cal./oz. can give the infant a sense of fullness without providing adequate nutrition (colostrum and breastmilk provide 17-20 cal. /oz.)^{13,25} • water supplements have not been shown to prevent or ameliorate hyperbilirubinemia in the neonatal period^{17,18} • higher protein levels in colostrum have a more stabilizing effect on blood glucose levels than glucose water^{17,18}
Perinatal caregivers will share recent recommendations with new mothers regarding the specific risks to the mother of not breastfeeding.	<p>Risks of not breastfeeding for the mother include:</p> <ul style="list-style-type: none"> • there is evidence to suggest that not breastfeeding increases a woman's risk of premenopausal breast cancer and ovarian cancer^{2,10,12,21} • artificial milks are less economical and less convenient^{2,27} • failure to breastfeed may increase the risk of postpartum bleeding due to a lack of oxytocin during the postpartum period^{2,12} • there is some evidence to suggest that not breastfeeding increases a woman's risk of osteoporosis^{2,12}

INTERVENTION/MANAGEMENT	RATIONALE
Support persons will be included in the lactation education and the decision making process.	Health care providers may influence breastfeeding by targeting people with influence over the mother's feeding choice. These may include the father of the baby, maternal grandmother or best friend.
The mother's health status will be considered in relation to HIV serology, chemical dependency, chemotherapy treatments and other medical conditions or therapies where breastfeeding may be contraindicated. Other medical conditions may require extra counseling and supervision.	<ul style="list-style-type: none"> • Breastfeeding is contraindicated for HIV positive mothers and mothers receiving chemotherapy^{17,18} • For other medical conditions or therapies, refer to a reliable reference to weigh the risks and benefits of breastfeeding¹⁹

POLICY # 4

REFERENCES

1. Ackerman, B., et al. The physiologic and neurobehavioral effects of a single cup feeding on 10 healthy preterm infants: Pilot study results.
2. American Academy of Pediatrics work group on breastfeeding. (1997). Breastfeeding and the use of human milk. *Pediatrics*, 100, 1035-1039.
3. American Academy of Pediatrics. (1994). Practice parameter: Management of hyperbilirubinemia in the healthy term newborn. *Pediatrics*, 94, 558-565.
4. Anderson, G. C. (1998). Risk in mother-infant separation postbirth. *Image: Journal of Nursing Scholarship*, 21, 196-199.
5. De Carvalho, M., et al. (1981). Effects of water supplementation on physiologic jaundice in breast-fed babies. *British Medical Journal*, 56, 568-569.
6. Dixit, R., & Gartner, L. (1999). The jaundiced newborn: Minimizing the risks. *Contemporary Pediatrics*, 16, 166-183.
7. Duncan, B., et al. (1993). Exclusive breastfeeding for at least 4 months protects against otitis media. *Pediatrics*, 91, 867-872.
8. El-Mohandes, A., et al. (1997). Use of human milk in the intensive care nursery decreases the incidence of nosocomial sepsis. *Journal of Perinatology*, 17, 130-134.
9. Gartner, L. (1994). On the question of the relationship between breastfeeding and jaundice in the first 5 days of life. *Seminars in Perinatology*, 18, 502-509.
10. Gwinn, M., et al. (1990). Pregnancy, breast feeding, and oral contraceptives and the risk of epithelial ovarian cancer. *Journal of Clinical Epidemiology*, 43, 559-568.
11. Heinig, J., & Dewey, K. (1996). Health advantages of breast feeding for infants: a critical review. *Nutrition Research Reviews*, 9, 89-110.
12. Heinig, J., & Dewey, K. (1997). Health effects of breast feeding for mothers: a critical review. *Nutrition Research Reviews*, 10, 35-56.
13. Henrikson, M. (1990). A policy for supplementary/complementary feedings for breastfed newborn infants. *Journal of Human Lactation*, 6(1), 11-14.
14. Herrera, A. J. (1984). Supplemented versus unsupplemented breastfeeding. *Perinatology/Neonatology*, May/June, 70-71.
15. Hill, P. D., et al. (1997). Does early supplementation affect long-term breastfeeding? *Clinical Pediatrics*, 36, 345-351.
16. Huggins, K. (1995). *The Nursing mother's companion* (3rd ed.). (pp. 14-16). Boston: Harvard Common Press.
17. Lawrence, R. A. (1987). The management of lactation as a physiologic process. *Clinics in Perinatology*, 14, 1-10.
18. Lawrence, R. A. (1994). *Breastfeeding: A guide for the medical professional* (4th ed.). St. Louis: C.V. Mosby.
19. Lawrence, R.A. (1997). A review of the medical benefits and contraindications to breastfeeding in the United States. *Maternal and Child Health Technical Information Bulletin*. Arlington, VA: National Center for Education in Maternal and Child Health.

20. Lucas, A., et al. (1992). Breast milk and subsequent intelligence quotient in children born preterm. *Lancet*, 339, 261-264.
21. Newcomb, P. A., et al. (1994). Lactation and a reduced risk of premenopausal breast cancer. *The New England Journal of Medicine*, 330, 81-87.
22. Newman, J. (1990). Breastfeeding problems associated with the early introduction of bottles and pacifiers. *Journal of Human Lactation*, 6, 59-63.
23. Pisacane, A., et al. (1992). Breastfeeding and urinary tract infection. *The Journal of Pediatrics*, 120, 87-89.
24. Pitt, J., et al. (1977). Protection against experimental necrotizing enterocolitis by maternal milk. I. Role of milk leukocytes. *Pediatric Res*, 11, 906-909.
25. Shrago, L. (1981). Glucose water supplementation of the breastfed infant during the first three days of life. *Journal of Human Lactation*, 3, 82-86.
26. Slusser, W., & Powers, N. (1997). Breastfeeding update I: Immunology, nutrition and advocacy. *Pediatrics in Review*, 18, 111-119.
27. Walker, M. (1992). *Summary of the hazards of infant formula*. International Lactation Consultant Association.
28. Walker, M. (1993). A fresh look at the risks of artificial infant feeding. *Journal of Human Lactation*, 9, 97-107.
29. White, E. et al. (1996). *Concerns about infant formula*. *The Healthy People 2000 project*. Entire document.
30. Winnikoff, B., et al. (1986). Dynamics of infant feeding: Mothers, professionals, and the institutional context in a large urban hospital. *Pediatrics*, 77, 357-365.

EXPANDED HOSPITAL POLICY #5

Assuming that the baby and mother are stable, the mother and baby will be skin-to-skin during the first several hours following birth. This includes the post-cesarean mother and baby. The baby will be encouraged to breastfeed ad lib without restriction. Nursing policies and practices will support care of the mother and infant together.

INTERVENTION/MANAGEMENT	RATIONALE
Mothers should breastfeed during the first hour following birth. For the normal newborn this should occur prior to such interventions as: the newborn bath, glucose sticks, foot printing, and eye treatments. This includes the post-cesarean mother and baby, when alert and stable.	Suck reflex is strongest 20-30 minutes post-birth. Delaying gratification can make it difficult for the infant to learn the suckling process. Early suckling allows the infant to receive the immunologic benefits of colostrum. Colostrum also stimulates digestive peristalsis. Suckling stimulates uterine involution and inhibits bleeding for the mother. Mothers should be permitted to engage in this normal physiological process regardless of birth method, as long as medically stable. Post-cesarean mothers may still be comfortable from epidural or spinal anesthesia. Temperature stabilization will almost always occur best with the baby in skin-to-skin contact on the mother's chest. ^{3,5,9,10,11,12,14,16}
Frequency and duration of feedings at the breast should be infant-led. Non-timed feedings and cue-based offerings will be the basis for mother infant care. The infant needs to have active suckling and swallowing time at the breast during each feeding.	It often takes 1.5-2 minutes after the onset of suckling and may take as long as 6-10 minutes for oxytocin release and subsequent milk ejection reflex. Limiting suckling time has not been shown to reduce nipple soreness or trauma and may result in a decreased milk supply and a delay of lactogenesis. ^{6,14,15}
Breastfeeding during the first day of life will take priority over other events such as infant bathing, pictures, and visitors.	Restricting breastfeeding may increase the degree of physiological engorgement that occurs during the transitional milk phase. ^{6,13}

INTERVENTION/MANAGEMENT	RATIONALE
<p>Newborns should be breastfed whenever they show signs of hunger, such as increased alertness or activity, mouthing or rooting, rapid eye movement sleep, and hand-to-mouth movement. Mothers will be assisted in identifying infant's hunger cues and readiness to feed. Crying is a late sign of hunger. Breastfeeding every 1-3 hours according to baby's cues will be supported by the nursing staff. The professional staff will help mothers respond to cues, observe and document infant for signs of adequate or inadequate output. If the professional staff is concerned with the baby's output before discharge, the mother should pump with a hospital grade electric breastpump and colostrum should be fed to the infant, avoiding use of an artificial nipple.</p>	<p>Breastmilk is digested in approximately 90 minutes. Eight to twelve feedings every 24 hours has been associated with increased meconium passage and lower serum bilirubin levels in the infant. Infants are more organized in their behavior and will breastfeed more successfully if they are not crying. Crying is a late sign of hunger. Maternal prolactin levels fall 3 hours after breastfeeding. Frequent and early feedings enhance duration of breastfeeding and enhance milk production. It is within normal range for babies to "cluster feed," by feeding several times close together and then going several hours without feeding. Normal, healthy newborns may breastfeed every hour, or several times in one hour, during the first days of life.^{1,4,5,8,9,14,15,18}</p>
<p>The lactation specialist should discuss the importance of colostrum with the mother. After appropriate education, however, a mother who feels very uncomfortable giving colostrum should be encouraged to pump and may discard the colostrum. This may be all that is needed to ensure an adequate beginning with breastfeeding. The lactation specialist should be aware of culture differences regarding colostrum and be trained to address these issues sensitively.</p>	<p>Some mothers may choose not to initiate early breastfeeding due to misinformation about the nature of colostrum. Some lactation specialists have reported that encouraging mothers to express and discard a small amount of the first milk has sufficed to get breastfeeding started.^{2,13}</p>
<p>Postpartum instructions for the mother will include information about "cluster feedings" and prepare her for growth spurts and other normal newborn breastfeeding patterns.</p>	<p>"Cluster feedings" and increased suckling time at the breast is often misinterpreted by the mother as evidence of insufficient milk. A common reason for early supplementation is the perception that frequent feedings are abnormal in the newborn. Cluster feedings and growth spurts need to be addressed early before the mother begins supplementation.^{13,17}</p>

POLICY # 5

REFERENCES

1. American Academy of Pediatrics work group on breastfeeding. (1997). Breastfeeding and the use of human milk. *Pediatrics*, 100, 1035-1039.
2. Bertelsen, C. & Auerbach, K. G. (1987). Nutrition and breastfeeding: The cultural connection. *Lactation Consultant Series*. La Leche League International.
3. Durand, R., et al. (1997). The effect of skin-to-skin breastfeeding in the immediate recovery period on newborn thermoregulation and blood glucose. *Neonatal Intensive Care*, March/April, 23-29.
4. Huggins, K. (1995). *The Nursing mother's companion* (3rd ed.). Boston: Harvard Common Press.
5. Kennell, J. H., & Klaus, M. H. (1998). Bonding: Recent observations that alter perinatal care. *Pediatrics in Review*, 19(1), 4-12.
6. L'Esperance, C., & Frantz, K. (1985). Time limitation for early breastfeeding. *JOGNN*, March/April, 114-118.
7. Lawrence, R. A. (1994). *Breastfeeding: A guide for the medical profession* (4th ed.). St. Louis: C.V. Mosby.
8. Lawrence, R. A. (1987). The management of lactation as a physiologic process. *Clinics in Perinatology*, 14, 1-10.
9. Ludington, S. M. (1990). Energy conservation during skin-to-skin contact between premature infants and their mothers. *Heart and Lung*, 19, 445-451.
10. Ludington-Hoe, S. M., & Swinth, J. Y. (1996). Developmental aspects of kangaroo care. *JOGNN*, 25, 691-703.
11. Ludington-Hoe, S. M., et al. (1994). Kangaroo care: Research results and practice implications and guidelines. *Neonatal Network*. 13(1), 19-27.
12. Righard, L., & Alade, M. (1990). Effect of delivery room routines on success of first breast-feed. *The Lancet*, 336, 1105-1107.
13. Riordan, J., & Auerbach, K. G. (1999). *Breastfeeding and human lactation* (2nd ed.). Sudbury, MA: Jones and Bartlett.
14. Salariya, E. M., et al. (1978). Duration of breastfeeding after early initiation and frequent feeding. *The Lancet*, Nov, 1141-1143.
15. Shrago, L., & Bocar, D. (1990). The infant's contribution to breastfeeding. *JOGNN*, 19, 209-215.
16. Taylor, P. M., et al. (1986). Early suckling and prolonged breast-feeding. *American Journal of Diseases of Children*, 140, 151-154.
17. Winnikoff, B., et al. (1986). Dynamics of infant feeding: Mothers, professionals, and the institutional context in a large urban hospital. *Pediatrics*, 77, 357-365.
18. Yamauchi, Y. & Yamanouchi, I. (1990). Breastfeeding frequency during the first 24 hours after birth in full term neonates. *Pediatrics*, 86, 171-175.

EXPANDED HOSPITAL POLICY #6

Every mother will be instructed in proper breastfeeding technique and assessed for proper latch-on at birth and at least once every 8 hours while in the hospital. When an assessment (for example, FAIB or LATCH) identifies a dysfunction or the infant displays signs of inadequate intake, a lactation consultation will be ordered.

INTERVENTION/MANAGEMENT	RATIONALE
The staff should assist the mother with breastfeeding and provide guidelines and support.	New mothers need consistent information and assistance in recognizing an adequate feeding. ^{2,3,7,13}
Pillows should be available to support mother's arms and bring the baby to breast level.	Nipple trauma can be prevented and nipple soreness minimized with proper attachment and positioning. Support and comfort of the mother and baby prevent fatigue and facilitate proper positioning of the baby at breast. ^{1,5,7,9,10,14}
A functional reassessment of the infant at the breast should be performed by a trained nurse, physician, or breastfeeding specialist within 8 hours of birth by utilizing an assessment tool such as FAIB or LATCH.	This provides for early identification of latch-on difficulties, as well as, direct observation of the infant at breast to assure adequate breastfeeding prior to discharge. Scoring can be misleading and inconsistent; however, assessment tools can help the provider identify areas of needed intervention. ^{1,5,12,13}
The perinatal nurse will respond to complaints of nipple soreness by assessing the source of the discomfort and assisting the mother in resolving the problem.	Physiological nipple tenderness occurs during the first few minutes of a feeding and eases during the same feeding. Pathological nipple soreness is considered whenever a mother complains of nipple soreness throughout an entire feeding or between feedings. ^{4,6,14}
Mother will be educated on the "supply and demand" principle of milk production.	Understanding of basic physiology enhances the lactation process. ^{2,3,13,18}

INTERVENTION/MANAGEMENT	RATIONALE
<p>The mother will be taught to recognize signs of effective sucking and listen for her baby's suckling and swallowing sounds.</p>	<p>Audible swallowing may be an important indicator of intake. Hearing the infant swallow is reassuring evidence that the baby is getting milk.^{1,5,13}</p>
<p>Mothers will be instructed and encouraged to watch the baby's cues and breastfeed on both breasts per feeding. Staff will help mothers to recognize the infant cues that indicate readiness to feed on the other breast.</p>	<p>Mother and staff should be alert to infant cues indicating readiness to feed or switch breasts. Timed feedings should be avoided. Hind milk, which comes later in the feed, is what makes the baby feel satiated. Arbitrarily removing the baby from the breast when the baby is actively suckling should be avoided. Doing this does not allow the baby to get a satisfying amount of hindmilk. Mothers usually feel more comfortable after feeding from both breasts. Watching cues is integral to finding this balance. An appropriate time to offer the second breast may be when suckling slows down or the infant falls asleep at the breast.^{6,7,11,13}</p>

POLICY # 6

REFERENCES

1. Bocar, D., & Shrago, L. (1990). *Functional assessment of the infant at the breast (FAIB)*. Oklahoma City, OK: Lactation Consultant Services.
2. Daly, S. E. J. & Hartmann, P. E. (1995). Infant demand and milk supply. Part 1: Infant demand and milk production in lactating women. *Journal of Human Lactation*, 11(1), 21-26.
3. Daly, S. E. J. & Hartmann, P. E. (1995). Infant demand and milk supply. Part 2: The short-term control of milk synthesis in lactating women. *Journal of Human Lactation*, 11(1), 27-37.
4. Huggins, K. (1995). *The Nursing mother's companion* (3rd ed.). (pp. 14-16). Boston: Harvard Common Press.
5. Jensen, D., et al. (1993). LATCH: A breastfeeding charting system and documentation tool. *JOGNN*, 23(1), 27-32.
6. L'Esperance, C., & Frantz, K. (1985). Time limitation for early breastfeeding. *JOGNN, March/April*, 114-118.
7. Lawrence, R. A. (1987). The management of lactation as a physiologic process. *Clinics in Perinatology*, 14, 1-10.
8. Lawrence, R. A. (1994). *Breastfeeding: A guide for the medical profession* (4th ed.). St. Louis: C.V. Mosby.
9. Marmet, C. & Shell, E. (1984). Training neonates to suck correctly. *Maternal Child Nursing*, 9, 401-407.
10. Newman, J. (1990). Breastfeeding problems associated with the early introduction of bottles and pacifiers. *Journal of Human Lactation*, 6, 59-63.
11. Righard, L., & Alade, M. (1992). Sucking technique and its effect on success of breastfeeding. *Birth*, 19, 185-189.
12. Riordan J. M., & Koehn, M. (1997). Reliability and validity testing of three breastfeeding assessment tools. *JOGNN*, 26, 181-187.
13. Schlomer, J. A., et al. (1999) Evaluating the association of two breastfeeding assessment tools with breastfeeding problems and breastfeeding satisfaction. *Journal of Human Lactation*, 15, 35-39.
14. Shrago, L., & Bocar, D. (1990). The infant's contribution to breastfeeding. *JOGNN*, 19, 209-215.
15. Walker, M., & Driscoll, J. (1989). Sore nipples: The new mother's nemesis. *MCN*, 14, 260-265.

EXPANDED HOSPITAL POLICY #7

Within the first 24-48 hours following birth, if feedings at the breast are incomplete, ineffective, or the mother is separated from her infant, the mother will be instructed to begin regular pumping of her breasts, with continued assistance by an experienced staff member. The colostrum or breastmilk obtained will be given to the baby unless contraindicated.

INTERVENTION/MANAGEMENT	RATIONALE
<p>The mother will be instructed in using the electric breast pump by an experienced staff member when the infant consistently demonstrates inadequate suckling or when prolonged separation of the mother and infant is expected from, for example, prematurity or illness. The mother will be given the opportunity to pump as soon after birth as medically feasible.</p>	<ul style="list-style-type: none"> • The electric pumping system is time-saving for the mother, and piston electric pumps most closely imitate the suck cycle of the infant.^{4,6,7} • Breast stimulation and breast emptying are necessary to initiate and maintain lactation.¹ • Following a protocol maintains consistency of information given to the parents.
<p>The expressed colostrum and breastmilk will be given to the infant in addition to any other supplement that may be indicated and prescribed by the physician.</p>	<p>This validates the mother's pumping efforts as valuable and provides added benefits to baby.^{4,6,7}</p>
<p>Discharge planning should include methods of expression of breastmilk including hand expression and/or pumping, with the method noted in the record. Include a family support person in the teaching process.</p>	<p>Emphasize the importance of regular breast expression in maintaining lactation. Expression sessions need to be part of her daily routine. Pumping frequency and length guidelines are based on the method of expression, taking into account baby's age and mother's ability to maintain enough volume to support her infant's needs. If her supply begins to decrease, increased frequency and duration of pumping may increase production. Involvement of mother's support persons will enhance her lactation experience.^{1,3,4,6,7}</p>

INTERVENTION/MANAGEMENT	RATIONALE
All mothers will be instructed in a method of hand expression prior to hospital discharge.	Hand expression may produce more milk due to the breast massage and skin contact involved with hand expression. ⁵

POLICY # 7

REFERENCES

1. Daly, S. E. J., & Hartmann, P. E. (1995). Infant demand and milk supply. Part 2: The short-term control of milk synthesis in lactating women. *Journal of Human Lactation*, 11, 27-37.
2. Frantz, K. (1994). *Breastfeeding product guide*. Sunland, CA: Geddes Productions..
3. Huggins, K. (1995). *The Nursing mother's companion* (3rd ed.). (pp. 85-97). Boston: Harvard Common Press.
4. Lawrence, R. A. (1994). *Breastfeeding: A guide for the medical profession* (4th ed.). St. Louis: C.V. Mosby.
5. Marmet, C. (1980, revised 1988). *Manual expression of breastmilk: Marmet technique*. Encino, CA: Lactation Institute Publications.
6. Marmet, C., & Shell, E. (1988). Instruments used in breastfeeding: A guide. In D. B. Jelliffe, & E. F. Jelliffe (Eds.), *Programmes to promote breastfeeding* (pp. 330-339). Oxford: University Press.
7. Riordan, J., & Auerbach, K. G. (1999). *Breastfeeding and human lactation* (2nd ed.). Sudbury, MA: Jones and Bartlett.

EXPANDED HOSPITAL POLICY #8

Pacifiers will not be given to breastfeeding infants.

INTERVENTION/MANAGEMENT	RATIONALE
Pacifiers will not be given to breastfeeding infants. Mothers will be encouraged to breastfeed frequently in response to hunger cues.	Breast stimulation is critical to milk production. When an infant needs to suck in the first days of life, the breast should be offered. The use of pacifiers may shorten the duration that a mother breastfeeds. ^{1,2,3,4,5,6}

POLICY # 8

REFERENCES

1. Howard, C. R., et al. (1999). The effects of early pacifier use on breastfeeding duration. *Pediatrics*, 103, 659.
2. Lawrence, R. A. (1987). The management of lactation as a physiologic process. *Clinics in Perinatology*, 14, 1-10.
3. Lawrence, R. A. (1994). *Breastfeeding: A guide for the medical profession* (4th ed.). St. Louis: C.V. Mosby.
4. Richard, L., & Alade, M. O. Breastfeeding and the use of pacifiers. *Birth*, 24, 116-120.
5. Victora, C. G., et al. (1997). Pacifier use and short breastfeeding duration: Cause, consequence, or coincidence? *Pediatrics*, 99, 445-453.
6. Victora, C. G., et al. (1993). Use of pacifiers and breastfeeding duration. *Lancet*, 341, 404-406.

EXPANDED HOSPITAL POLICY #9

Supplementary water or artificial infant milk will not be given to breastfeeding infants unless specifically ordered for a clinical condition by the physician. Maternal consent specifying the risks of introducing artificial infant milk to the newborn will be required prior to beginning artificial feeding of any infant.

INTERVENTION/MANAGEMENT	RATIONALE
Breastfeeding infants will be given only breastmilk. Sterile water, glucose water or artificial infant milk feedings will not be a part of the standard orders and will not be given without a specific written order by the attending physician.	Colostrum and breastmilk will completely meet the normal newborn's nutritional and fluid needs (provides 17-20 cal./oz.). ^{8,9} Colostrum is the least noxious substance if aspirated. ^{8,9} Water interferes with breastfeeding and fills the baby with non-nutritive fluid so that the baby is not hungry. This decreases the frequency of breastfeeding, which in turn decreases the mother's milk supply. ^{3,4,5,8}
When supplementation is medically indicated, an alternate feeding method should be utilized to maintain mother-infant breastfeeding skills. Artificial feeding should not exceed the physiologic capacity of the newborn stomach.	Some infants may have difficulty transitioning between an artificial nipple and the breast. Alternate feeding methods may be helpful in maintaining breastfeeding skills. Alternate feeding methods include cup, dropper, gavage, finger or syringe. Care should be taken to not exceed the physiologic capacity of the newborn stomach. In the first few days of life, volumes of less than 20 cc should be given at each feeding. ^{1,2,7,9,10,11}
Education regarding supplementation will be presented prior to obtaining a consent for supplementation (Appendix II). Risks of introducing artificial infant milk and/or water to the newborn will be discussed with the mother prior to supplementation.	Note policy # 4 for a list of potential risks for the infant who receives artificial infant milk or water or is fed by artificial feeding methods.

POLICY # 9

REFERENCES

1. Ackerman, B., et al. The physiologic and neurobehavioral effects of a single cup feeding on 10 healthy preterm infants: Pilot study results.
2. Henrikson, M. (1990). A policy for supplementary/complementary feedings for breastfed newborn infants. *Journal of Human Lactation*, 6(1), 11-14.
3. Herrera, A. J. (1984). Supplemented versus unsupplemented breastfeeding. *Perinatology/Neonatology*, May/June, 70-71.
4. Hill, P. D., et al. (1997). Does early supplementation affect long-term breastfeeding? *Clinical Pediatrics*, 36, 345-351.
5. King, Colin (Director). (1994). The Ameda Egnell baby cup (videotape). (Available from Ameda/Egnell, 755 Industrial Dr., Cary, Illinois 60013)
6. Kliethermes, P., et al. (1999). Transitioning preterm infants with nasogastric tube supplementation: Increased likelihood of breastfeeding. *JOGNN*, 28, 264-273.
7. Lang, S., et al. (1994). Cup feeding: an alternative method of infant feeding. *Archives of Disease in Childhood*, 71, 365-369.
8. Lawrence, R. A. (1987). The management of lactation as a physiologic process. *Clinics in Perinatology*, 14, 1-10.
9. Lawrence, R. A. (1994). *Breastfeeding: A guide for the medical profession* (4th ed.). St. Louis: C.V. Mosby.
10. Marmet, C. (1984). Training neonates to suck correctly. *Journal of Maternal Child Nursing*, 9, 401-407.
11. Newman, J. (1990). Breastfeeding problems associated with the early introduction of bottles and pacifiers. *Journal of Human Lactation*, 6, 59-63.

EXPANDED HOSPITAL POLICY #10

Infants should remain at the mother's bedside both day and night. The nurse should plan with the mother and family for periods of rest and sleep.

INTERVENTION/MANAGEMENT	RATIONALE
Babies will be cared for at their mothers' bedside. Mother and family will be encouraged to assist with infant care.	Bonding, adaptation to extra-uterine life, and attachment are facilitated by the infant being with the mother. Caring for mother and baby together provides the opportunity for individualized teaching and enhances the mother's ability to learn her baby's cues. ^{1,4,7,8}
The nurse may plan with the mother and family for at least 1-2 hours of undisturbed time to be with and focus on her baby during the hospital stay.	Rest is an important physiologic and psychological need for all postpartum, lactating mothers. With liberalized visiting hours, there may be limited time for mothers to rest, unless naps are planned. ^{2,3,9}
If, after encouragement to room in, the mother requests the baby to stay in the nursery at night, the infant should be brought to the mother to breastfeed when the baby displays hunger cues or every three hours, whichever is sooner.	Prolactin levels are highest at night and may contribute to optimal breastfeeding. Rooming-in provides additional opportunities for mothers and babies to establish effective nursing patterns prior to discharge. ^{3,6,12}
Evidence of patient teaching and professional recommendations will be documented in the patient's chart. An informed consent for supplementation plus a statement indicating the mother's request not to breastfeed during the night will be included in the patient chart.	Due to potential complications for mother and baby related to early supplementation of the breastfed infant, informed consent is essential. The mother needs to understand clearly the risks of introduction of artificial nipples, early introduction of artificial infant milk, and failure to optimally provide colostrum to the newborn (note policy #4).

INTERVENTION/MANAGEMENT	RATIONALE
<p>If the mother is unable or refuses to feed her infant during the night, the infant will be fed in a manner that is consistent with preserving breastfeeding and reflects the skills and knowledge of the nursery staff in consultation with the infant's physician. Alternative feeding methods such as cup, finger, or tube feedings should be used to provide adequate calories to the newborn. Alternative feedings should include colostrum or breastmilk if available. The use of pacifiers, bottles with artificial nipples and water feedings will be discouraged (note policies #4 and #9).</p>	<p>California law and hospital regulations guarantee the baby a safe place to be during the hospital stay. If the mother chooses not to participate in rooming-in or chooses not to breastfeed her baby during the night, it is the responsibility of the staff in consultation with the patient's physician to provide care that will best promote the long-term health of the mother and infant. Mothers who receive sedative drugs, are out of the room for surgical procedures or have an altered state of alertness should not bed-in with their newborn.¹⁰</p>

POLICY # 10

REFERENCES

1. Anderson, G. C. (1989). Risk in mother-infant separation postbirth. *Image: Journal of Nursing Scholarship*, 21, 196-199.
2. Keefe, M. R. (1988). The impact of infant rooming-in on maternal sleep at night. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, Mar/Apr, 122-126.
3. Lawrence, R. A. (1994). *Breastfeeding: A guide for the medical profession* (4th ed.). St. Louis: C.V. Mosby.
4. Marasco, L. (1998). Cue vs scheduled feeding: Revisiting the controversy. *Mother Baby Journal*, 3 (4), 39-42.
5. Marmet, C., & Shell, E. (1988). Instruments used in breastfeeding: A guide. In D. B. Jelliffe, & E. F. Jelliffe (Eds.), *Programmes to Promote Breastfeeding* (pp. 330-339). Oxford: University Press.
6. McKenna, J. J., et al. (1997). Bedsharing promotes breastfeeding. *Pediatrics*, 100, 214-219.
7. Mosko, S., et al. (1997). Infant arousal during mother-infant bed sharing: Implications for infant sleep and sudden infant death syndrome research. *Pediatrics*, 100, 841-849.
8. NAACOG OGN Nursing Practice Resource. (March 1989). *Mother-baby care*.
9. Riordan, J., & Auerbach, K. G. (1999). *Breastfeeding and human lactation* (2nd ed.). Sudbury, MA: Jones and Bartlett.
10. Title 22 Licensing and Certification of Health Facilities and Referral Agencies. Article 70547, Section (k), page 789.
11. Winikoff, B., et al. (1987). Overcoming obstacles to breastfeeding in a large municipal hospital: Application of lessons learned. *Pediatrics*, 80, 423-433.
12. Yamauchi, Y., & Yamanouchi, I. (1990). The relationship between rooming-in/not rooming-in and breast-feeding variables. *Acta Paediatrica Scandinavica*, 79, 1017-1022.

EXPANDED HOSPITAL POLICY #11

At discharge, each mother will be referred to a breastfeeding support group and given the telephone number of a lactation specialist/consultant or community resource for breastfeeding assistance. Commercial advertising or promotional packs should not be given to any mother whether bottle-feeding or breastfeeding.

INTERVENTION/MANAGEMENT	RATIONALE
Patients will routinely be given a phone number to call and means of contacting other community resources for breastfeeding assistance.	Discharge often occurs before lactation and breastfeeding are well established. ^{3,6,7,8,11}
Postpartum follow-up calls will be provided for all mothers. This will provide an opportunity for offering support, identifying early problems and referring lactating mothers to appropriate resources.	Mothers are unlikely to call the care provider for breastfeeding assistance, however, mothers often have transient breastfeeding difficulties that can be resolved with reassurance and support from an experienced care provider. Early interventions for breastfeeding challenges can often avoid the detrimental effects of introducing artificial infant milk. ^{3,5,6,7,8,11}
Nurses who are concerned about an infant's ability to latch on should inform the attending physician. Physicians will be educated to support the nutritional needs of the infant and support the mother's desire to breastfeed.	Nurses and physicians can assist in development and implementation of a discharge plan, which can meet both the infant's nutritional needs and the mother's breastfeeding goals. ^{3,9}
Gift packs containing items that discourage or negatively affect breastfeeding should not be given to any mother at discharge. These packs might contain pacifiers, formula, bottles, breast pumps, infant cereals, plastic-lined breast pads and electrolyte replacement solutions.	Hospitals should carefully consider any items they give to mothers. Providing items to patients suggests hospital endorsement of these products. Giving formula advertising or promotional packs endorses supplementation and implies that breastmilk is inadequate to meet infants' needs. Hospital policies regarding patient and staff contact with pharmaceutical representatives should be enforced. ^{1,2,4}

POLICY # 11

REFERENCES

1. Chezem, J. C., et al. (1998). Lactation duration: Influences of human milk replacements and formula samples on women planning postpartum employment. *JOGNN*, 27, 646-651.
2. Dungy, C. I., et al. (1992). Effects of discharge samples on duration of breastfeeding. *Pediatrics*, 90, 233-237.
3. Gartner, L., & Newton, E. (1998). Breastfeeding: Role of the obstetrician. *ACOG Clinical Review*, 3(1), 1-15.
4. Howard, F. M., et al. (1993). The physician as advertiser: The unintentional discouragement of breastfeeding. *Obstetrics and Gynecology*, 81, 1048-1051.
5. Lawrence, R. A. (1987). The management of lactation as a physiologic process. *Clinics in Perinatology*, 14, 1-10.
6. Locklin, M. P., & Jansson, M. J. (1999). Home visits: Strategies to protect the breastfeeding newborn at risk. *JOGNN*, 28, 33-40.
7. Moore, E. R., et al. (1991). A community hospital-based breastfeeding counseling service. *Pediatric Nursing*, 17, 383-389.
8. Page-Goertz, S. (1989). Discharge planning for the breastfeeding dyad. *Pediatric Nursing*, 15, 543-544.
9. Shrago, L. (1981). Glucose water supplementation of the breastfed infant during the first three days of life. *Journal of Human Lactation*, 3, 82-86.
10. Shrago, L., & Bocar, D. (1990). The infant's contribution to breastfeeding. *JOGNN*, 19, 209-215.
11. Wright, A., & Rice, S. (1996). Changing hospital practices to increase the duration of breastfeeding. *Pediatrics*, 97, 669-675.

EXPANDED HOSPITAL POLICY #12

Hospital administration will foster formation of breastfeeding support groups.

INTERVENTION/MANAGEMENT	RATIONALE
The hospital administration will provide space and cover operational costs to support local community lactation support groups or hospital-based breastfeeding support groups.	Ongoing peer support groups lead to increased success and increased duration of breastfeeding ^{1,2,3} (note policy #11).

POLICY # 12

REFERENCES

1. Locklin, M. P., & Jansson, M. J. (1999). Home visits: Strategies to protect the breastfeeding newborn at risk. *JOGNN*, 28, 33-40.
2. Moore, E. R., et al. (1991). A community hospital-based breastfeeding counseling service. *Pediatric Nursing*, 17, 383-389.
3. Page-Goertz, S. (1989). Discharge planning for the breastfeeding dyad. *Pediatric Nursing*, 15, 543-544.

Using the Hospital Self Appraisal Tool to Review Policies and Practices

Any hospital or health facility that is interested in receiving a Certificate of Intent to Support the Principles of the Global Baby-Friendly Hospital Initiative should—as a first step—appraise its current practices in relation to the Ten Steps to Successful Breastfeeding.

The checklist that follows will permit a hospital, birthing center, or other health facility giving maternity care to make a quick initial appraisal or review of its practices in support of breastfeeding. Completion of this initial self-review form is the first stage of the process of meeting the requirements to receive a Certificate of Intent from the U.S. Committee for UNICEF. (In the United States, the baby-friendly designation process is still being developed; final recommendations will be issued in 1994.)

Hospitals are encouraged to bring their key management and clinical staff together to review the Self Appraisal Tool and develop a plan of action based on the results of the self appraisal. Suggestions for specific action for an in-house group of hospital management and clinical staff are to establish 1) a written breastfeeding policy, 2) a written curriculum for any training in lactation management given to hospital staff caring for mothers and babies, 3) a written outline of the content to be covered in antenatal health education about breastfeeding. Existence of such written documents provides evidence of on-going institutional commitment to breastfeeding and ensures continued promotion even with changes in staff. Consultation with the U.S. Committee for UNICEF can provide more information on policies and training that will contribute to increasing the Baby-Friendliness of health facilities.

For more information contact:
Minda Lazarov
U.S. Committee for UNICEF
615-322-2470

HOSPITAL DATA SHEET

Date _____, 19 _____

If no nursery for normal well newborns exists, write "none" in space provided.

Hospital Name: _____

Address: _____

City, District, or Region: _____ Country: _____

Name of Chief Hospital Administrator: _____ Telephone: _____

Names of senior Nursing Officers (or other personnel in charge):

For the Facility: _____

Telephone: _____

For the Maternity Ward: _____

Telephone: _____

For the Antenatal Service: _____

Telephone: _____

Name of person to be contacted for additional information: _____

Type of Hospital:	Government	Private - Not for profit	Private - For profit
	Mission	Teaching	Other: _____

HOSPITAL CENSUS DATA:

Total bed capacity: _____

_____ in labour and delivery area

_____ in the maternity ward

_____ in the normal nursery

_____ in the special care nursery

_____ in other areas for mothers and children

Total Deliveries in year 199____: _____

_____ were by Caesarean

_____ were low birth weight babies (<2500g)

_____ were in special care

Caesarean rate _____%

Low birth weight rate _____%

Special care rate _____%

Infant feeding data for deliveries from records or staff reports:

_____ mother /infant pairs discharged in the past month

_____ mother/infant pairs breastfeeding at discharge in the past month _____%

_____ mother/infant pairs breastfeeding exclusively from birth to discharge in the past month _____%

_____ infants discharged in the past month who have received at least one bottlefeed since birth _____%

How was the infant feeding data obtained?

_____ From records

_____ Percentages are an estimate, provided by: _____

Name of person(s) filling out this form:

STEP 1. Have a written breastfeeding policy that is routinely communicated to all health care staff.

- 1.1 Does the health facility have an explicit written policy for protecting, promoting, and supporting breastfeeding that addresses all 10 steps to successful breastfeeding in maternity services Yes ☐ No ☐
- 1.2 Does the policy protect breastfeeding by prohibiting all promotion of and group instruction for using breastmilk substitutes, feeding bottles and teats? Yes ☐ No ☐
- 1.3 Is the breastfeeding policy available so all staff who take care of mothers and babies can refer to it? Yes ☐ No ☐
- 1.4 Is the breastfeeding policy posted or displayed in all areas of the health facility which serve mothers, infants, and/or children? Yes ☐ No ☐
- 1.5 Is there a mechanism for evaluating the effectiveness of the policy? Yes ☐ No ☐

STEP 2. Train all health care staff in skills necessary to implement this policy.

- 2.1 Are all staff aware of the advantages of breastfeeding and acquainted with the facility's policy and services to protect, promote, and support breastfeeding?. Yes ☐ No ☐
- 2.2 Are all staff caring for women and infants oriented to the breastfeeding policy of the hospital on their arrival?. Yes ☐ No ☐
- 2.3 Is training on breastfeeding and lactation management given to all staff caring for women and infants within six months of their arrival? Yes ☐ No ☐
- 2.4 Does the training cover at least eight of the Ten Steps to Successful Breastfeeding? Yes ☐ No ☐
- 2.5 Is the training on breastfeeding and lactation management at least 18 hours in total, including a minimum of 3 hours of supervised clinical experience? Yes ☐ No ☐
- 2.6 Has the healthcare facility arranged for specialized training in lactation management of specific staff members? Yes ☐ No ☐

STEP 3. Inform all pregnant women about the benefits and management of breastfeeding.

- 3.1 Does the hospital include an antenatal care clinic? Or an antenatal inpatient ward? Yes ☐ No ☐
- 3.2 If yes, are most pregnant women attending these antenatal services informed about the benefits and management of breastfeeding? Yes ☐ No ☐

- 3.3 Do antenatal records indicate whether breastfeeding has been discussed with the pregnant woman? Yes ☐ No ☐
- 3.4 Is a mother's antenatal record available at the time of delivery? Yes ☐ No ☐
- 3.5 Are pregnant women protected from oral or written promotion of group instruction for artificial feeding? Yes ☐ No ☐
- 3.6 Does the healthcare facility take into account a woman's intention to breastfeed when deciding on the use of a sedative, an analgesic, or an anesthetic, (if any) during labour and delivery? Yes ☐ No ☐
- 3.7 Are staff familiar with the effects of such medicaments on breastfeeding? Yes ☐ No ☐
- 3.8 Does a woman who has never breastfed or who has previously encountered problems with breastfeeding receive special attention and support from the staff of the healthcare facility? Yes ☐ No ☐

STEP 4. Help mothers initiate breastfeeding within a half-hour of birth.

- 4.1 Are mothers whose deliveries are normal given their babies to hold, with skin contact, within a half-hour of completion of the second stage of labour and allowed to remain with them for at least the first hour? Yes ☐ No ☐
- 4.2 Are the mothers offered help by a staff member to initiate breastfeeding during this first hour? Yes ☐ No ☐
- 4.3 Are mothers who have had caesarean deliveries given their babies to hold, with skin contact, within a half hour after they are able to respond to their babies? Yes ☐ No ☐
- 4.4 Do the babies born by caesarean stay with their mothers, with skin contact, at this time for at least 30 minutes? Yes ☐ No ☐

STEP 5. Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.

- 5.1 Does nursing staff offer all mothers further assistance with breastfeeding within six hours of delivery? Yes ☐ No ☐
- 5.2 Are most breastfeeding mothers able to demonstrate how to correctly position and attach their babies for breastfeeding? Yes ☐ No ☐
- 5.3 Are breastfeeding mothers shown how to express their milk or given information on expression and/or advised of where they can get help, should they need it? Yes ☐ No ☐

- 5.4 Are staff members or counselors who have specialized training in breastfeeding and lactation management available full-time to advise mothers during their stay in healthcare facilities and in preparation for discharge? Yes ☐ No ☐
- 5.5 Does a woman who has never breastfed or who has previously encountered problems with breastfeeding receive special attention and support from the staff of the healthcare facility? Yes ☐ No ☐
- 5.6 Are mothers of babies in special care helped to establish and maintain lactation by frequent expression of milk? Yes ☐ No ☐

STEP 6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.

- 6.1 Do staff have a clear understanding of what the few acceptable reasons are for prescribing food or drink other than breastmilk for breastfeeding babies? Yes ☐ No ☐
- 6.2 Do breastfeeding babies receive no other food or drink (than breastmilk) unless medically indicated? Breastmilk only. Yes ☐
Some other food/drink No ☐
- 6.3 Are any breastmilk substitutes including special formulas which are used in the facility purchased in the same way as any other foods or medicines? Yes ☐ No ☐
- 6.4 Do health facility and health care workers refuse free or low-cost* supplies of breastmilk substitutes, paying close to retail market price for any? Yes ☐ No ☐
- 6.5 Is all promotion of infant foods or drinks other than breastmilk absent from the facility? Yes ☐ No ☐

STEP 7. Practice rooming-in—allow mothers and infants to remain together— 24 hours a day.

- 7.1 Do mothers and infants remain together (rooming-in or bedding-in) 24 hours a day, except for periods of up to an hour for hospital procedures or if separation is medically indicated? Yes ☐ No ☐
- 7.2 Does rooming-in start within an hour of a normal birth? Yes ☐ No ☐
- 7.3 Does rooming-in start within an hour when a caesarean mother can respond to her baby? Yes ☐ No ☐

STEP 8. Encourage breastfeeding on demand.

8.1 By placing no restrictions on the frequency or length of breastfeeds, do staff show they are aware of the importance of breastfeeding on demand? Yes ☐ No ☐

8.2 Are mothers advised to breastfeed their babies whenever their babies are hungry and as often as their babies want to breastfeed?. Yes ☐ No ☐

STEP 9. Give no artificial teats or pacifiers (also called dummies or soothers to breastfeeding infants.

9.1 Are babies who have started to breastfeed cared for without any bottlefeeds?. Yes ☐ No ☐

9.2 Are babies who have started to breastfeed cared for without using pacifiers?. Yes ☐ No ☐

9.3 Do breastfeeding mothers learn that they should not give any bottles or pacifiers to their babies?. Yes ☐ No ☐

9.4 By accepting no free or low-cost feeding bottles, teats, or pacifiers, do the facility and the health workers demonstrate that these should be avoided?. Yes ☐ No ☐

STEP 10. Foster the establishment of breastfeeding support and refer mothers to them on discharge from the hospital or clinic.

10.1 Does the hospital give education to key family members so that they can support the breastfeeding mother at home?. Yes ☐ No ☐

10.2 Are breastfeeding mothers referred to breastfeeding support groups, if any are available?. Yes ☐ No ☐

10.3 Does the hospital have a system of follow-up support for breastfeeding mothers after they are discharged, such as early postnatal or lactation clinic check-ups, home visits, telephone calls?. Yes ☐ No ☐

10.4 Does the facility encourage and facilitate the formation of mother-to-mother or healthcare worker-to-mother support groups?. Yes ☐ No ☐

10.5 Does the facility allow breastfeeding counseling by trained mother-support group counselors in its maternity services?. Yes ☐ No ☐

**APPENDIX
TO THE
UNITED STATES BABY-FRIENDLY HOSPITAL INITIATIVE
GUIDELINES AND CRITERIA**

Acceptable medical reasons for supplementation

A few medical indications in a maternity facility may require that individual infants be given fluids or food in addition to, or in place of, breastmilk.

It is assumed that severely ill babies, babies in need of surgery, and very low birth weight infants will be in a special care unit. Their feeding will be individually decided, given their particular nutritional requirements and functional capabilities, though breastmilk is recommended whenever possible. These infants in special care are likely to include:

- ◆ infants with very low birth weight (less than 1500 grams) or who are born before 32 weeks gestational age
- ◆ infants with severe dysmaturity with potentially severe hypoglycemia, or who require therapy for hypoglycemia, and who do not improve through increased breastfeeding or by being given breastmilk

For babies who are well enough to be with their mothers on the maternity ward, there are very few indications for supplements, in order to assess whether a facility is inappropriately using fluids or breastmilk substitutes, any infants receiving additional supplements must have been diagnosed as:

- ◆ infants whose mothers have severe maternal illness (e.g. psychosis, eclampsia, or shock)
- ◆ infants with inborn errors of metabolism (e.g. galactosemia, phenylketonuria, maple syrup urine disease)
- ◆ infants with acute water loss, for example during phototherapy for jaundice, whenever increased breastfeeding or use of expressed breastmilk cannot provide adequate hydration
- ◆ infants whose mothers require medication which is contraindicated when breastfeeding (e.g. cytotoxic drugs, radioactive drugs, and anti-thyroid drugs other than propylthiouracil)

When breastfeeding has to be temporarily delayed, interrupted, or supplemented, mothers should be helped to establish or maintain lactation, or example through manual or hand-pump expression of milk, in preparation for the moment when full breastfeeding may be begun or resumed. If the interruption is due to problems with the infant, milk can be expressed, stored if necessary, and provided to the infant as soon as medically advisable, if it is due to a maternal medication or disease which negatively affects the quality of milk, the milk should be pumped and discarded.

Consent to Supplement Newborn Infants

The American Academy of Pediatrics says that routine supplements of formula for breastfed infants should not be used. The nursery at "XYZ" Hospital does not routinely supplement babies with water or formula for the following reasons:

- Cow's milk formula can set up a potential allergic response.
- The suck on a bottle is different from the suck on a breast. A breastfed baby can become nipple confused and have difficulty latching on to the breast.
- Formula is slower to digest than human milk which increases the time between feedings.
- Studies have shown feeding a healthy term newborn on demand without supplements encourages early milk production (24-48 hrs.), decreases chances of jaundice and provides better weight gain for infants.

DATE: _____ TIME: _____ AM
PM

I, _____, authorize the nurses to supplement
(Patient's Signature)

_____ with _____
(Baby's Name) (Sterile Water, Glucose Water, Formula)

_____ in the following situations:

_____ at mother's discretion _____ during the night
_____ if baby continues to cry after nursing
_____ during phototherapy sessions

Signature of Mother

Witness

SAMPLE INSURANCE LETTER

Date:

RE:

Insured:

Policy #

The following explanation of medical necessity is provided in order to expedite authorization of insurance coverage for an electric breast pump.

Your member _____ delivered an infant _____ on _____, and the child is too _____ (ill or immature) to breastfeed. It is well established that breast milk provides optimal infant nutrition for the first several months of life. Therefore, I encourage all mothers of premature or high risk newborns to pump their breasts in order to supply milk for their hospitalized infants and to maintain lactation until their baby can breastfeed.

The intermittent electric breast pump is by far the most efficient and effective means of simulating the sucking action of a breastfeeding infant. Hand, battery and small electric pumps are an adjunct to milk expression for occasional use when a breastfeeding infant and mother are separated for a short time. A piston style electric pump is essential for the maintenance of an adequate milk supply whenever the child is unable to breastfeed. Such pumps cost \$900.00 to purchase. We expect this mother to need to pump for a minimum of _____ weeks. Pump rental costs approximately _____ per month.

The electric pump will be necessary until the infant is able to take all required nutrition by breastfeeding (anticipated date _____). An electric breast pump is not just a convenience for the mother, but also a medical necessity for this child.

Sincerely,

Neonatologist

AMERICAN ACADEMY OF PEDIATRICS

Work Group on Breastfeeding

Breastfeeding and the Use of Human Milk

ABSTRACT. This policy statement on breastfeeding replaces the previous policy statement of the American Academy of Pediatrics, reflecting the considerable advances that have occurred in recent years in the scientific knowledge of the benefits of breastfeeding, in the mechanisms underlying these benefits, and in the practice of breastfeeding. This document summarizes the benefits of breastfeeding to the infant, the mother, and the nation, and sets forth principles to guide the pediatrician and other health care providers in the initiation and maintenance of breastfeeding. The policy statement also delineates the various ways in which pediatricians can promote, protect, and support breastfeeding, not only in their individual practices but also in the hospital, medical school, community, and nation.

ABBREVIATION. AAP, American Academy of Pediatrics.

HISTORY AND INTRODUCTION

From its inception, the American Academy of Pediatrics (AAP) has been a staunch advocate of breastfeeding as the optimal form of nutrition for infants. One of the earliest AAP publications was a 1948 manual, *Standards and Recommendations for the Hospital Care of Newborn Infants*. This manual included a recommendation to make every effort to have every mother nurse her full-term infant. A major concern of the AAP has been the development of guidelines for proper nutrition for infants and children. The activities, statements, and recommendations of the AAP have continuously promoted breastfeeding of infants as the foundation of good feeding practices.

THE NEED

Extensive research, especially in recent years, documents diverse and compelling advantages to infants, mothers, families, and society from breastfeeding and the use of human milk for infant feeding. These include health, nutritional, immunologic, developmental, psychological, social, economic, and environmental benefits.

Human milk is uniquely superior for infant feeding and is species-specific; all substitute feeding options differ markedly from it. The breastfed infant is the reference or normative model against which all alternative feeding methods must be measured with regard to growth, health, development, and all other short- and long-term outcomes.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.
PEDIATRICS (ISSN 0031 4005). Copyright © 1997 by the American Academy of Pediatrics.

Epidemiologic research shows that human milk and breastfeeding of infants provide advantages with regard to general health, growth, and development, while significantly decreasing risk for a large number of acute and chronic diseases. Research in the United States, Canada, Europe, and other *developed* countries, among predominantly middle-class populations, provides strong evidence that human milk feeding decreases the incidence and/or severity of diarrhea,¹⁻⁵ lower respiratory infection,⁶⁻⁹ otitis media,^{3,10-14} bacteremia,^{15,16} bacterial meningitis,^{15,17} botulism,¹⁸ urinary tract infection,¹⁹ and necrotizing enterocolitis.^{20,21} There are a number of studies that show a possible protective effect of human milk feeding against sudden infant death syndrome,²²⁻²⁴ insulin-dependent diabetes mellitus,²⁵⁻²⁷ Crohn's disease,^{28,29} ulcerative colitis,²⁹ lymphoma,^{30,31} allergic diseases,³²⁻³⁴ and other chronic digestive diseases.³⁵⁻³⁷ Breastfeeding has also been related to possible enhancement of cognitive development.^{38,39}

There are also a number of studies that indicate possible health benefits for mothers. It has long been acknowledged that breastfeeding increases levels of oxytocin, resulting in less postpartum bleeding and more rapid uterine involution.⁴⁰ Lactational amenorrhea causes less menstrual blood loss over the months after delivery. Recent research demonstrates that lactating women have an earlier return to prepregnant weight,⁴¹ delayed resumption of ovulation with increased child spacing,⁴²⁻⁴⁴ improved bone remineralization postpartum⁴⁵ with reduction in hip fractures in the postmenopausal period,⁴⁶ and reduced risk of ovarian cancer⁴⁷ and premenopausal breast cancer.⁴⁸

In addition to individual health benefits, breastfeeding provides significant social and economic benefits to the nation, including reduced health care costs and reduced employee absenteeism for care attributable to child illness. The significantly lower incidence of illness in the breastfed infant allows the parents more time for attention to siblings and other family duties and reduces parental absence from work and lost income. The direct economic benefits to the family are also significant. It has been estimated that the 1993 cost of purchasing infant formula for the first year after birth was \$855. During the first 6 weeks of lactation, maternal caloric intake is no greater for the breastfeeding mother than for the nonlactating mother.^{49,50} After that period, food and fluid intakes are greater, but the cost of this increased caloric intake is about half the cost of purchasing formula. Thus, a saving of >\$400 per child

for food purchases can be expected during the first year.^{51,52}

Despite the demonstrated benefits of breastfeeding, there are some situations in which breastfeeding is not in the best interest of the infant. These include the infant with galactosemia,^{53,54} the infant whose mother uses illegal drugs,⁵⁵ the infant whose mother has untreated active tuberculosis, and the infant in the United States whose mother has been infected with the human immunodeficiency virus.^{56,57} In countries with populations at increased risk for other infectious diseases and nutritional deficiencies resulting in infant death, the mortality risks associated with not breastfeeding may outweigh the possible risks of acquiring human immunodeficiency virus infection.⁵⁸ Although most prescribed and over-the-counter medications are safe for the breastfed infant, there are a few medications that mothers may need to take that may make it necessary to interrupt breastfeeding temporarily. These include radioactive isotopes, antimetabolites, cancer chemotherapy agents, and a small number of other medications. Excellent books and tables of drugs that are safe or contraindicated in breastfeeding are available to the physician for reference, including a publication from the AAP.⁵⁵

THE PROBLEM

Increasing the rates of breastfeeding initiation and duration is a national health objective and one of the goals of Healthy People 2000. The target is to "increase to at least 75% the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50% the proportion who continue breastfeeding until their babies are 5 to 6 months old."⁵⁹ Although breastfeeding rates have increased slightly since 1990, the percentage of women currently electing to breastfeed their babies is still lower than levels reported in the mid-1980s and is far below the Healthy People 2000 goal. In 1995, 59.4% of women in the United States were breastfeeding either exclusively or in combination with formula feeding at the time of hospital discharge; only 21.6% of mothers were nursing at 6 months, and many of these were supplementing with formula.⁶⁰

The highest rates of breastfeeding are observed among higher-income, college-educated women >30 years of age living in the Mountain and Pacific regions of the United States.⁶⁰ Obstacles to the initiation and continuation of breastfeeding include physician apathy and misinformation,⁶¹⁻⁶³ insufficient prenatal breastfeeding education,⁶⁴ disruptive hospital policies,⁶⁵ inappropriate interruption of breastfeeding,⁶² early hospital discharge in some populations,⁶⁶ lack of timely routine follow-up care and postpartum home health visits,⁶⁷ maternal employment^{68,69} (especially in the absence of workplace facilities and support for breastfeeding),⁷⁰ lack of broad societal support,⁷¹ media portrayal of bottle-feeding as normative,⁷² and commercial promotion of infant formula through distribution of hospital discharge packs, coupons for free or discounted formula, and television and general magazine advertising.^{73,74}

The AAP identifies breastfeeding as the ideal

method of feeding and nurturing infants and recognizes breastfeeding as primary in achieving optimal infant and child health, growth, and development. The AAP emphasizes the essential role of the pediatrician in promoting, protecting, and supporting breastfeeding and recommends the following breastfeeding policies.

RECOMMENDED BREASTFEEDING PRACTICES

1. Human milk is the preferred feeding for all infants, including premature and sick newborns, with rare exceptions.⁷⁵⁻⁷⁷ The ultimate decision on feeding of the infant is the mother's. Pediatricians should provide parents with complete, current information on the benefits and methods of breastfeeding to ensure that the feeding decision is a fully informed one. When direct breastfeeding is not possible, expressed human milk, fortified when necessary for the premature infant, should be provided.^{78,79} Before advising against breastfeeding or recommending premature weaning, the practitioner should weigh thoughtfully the benefits of breastfeeding against the risks of not receiving human milk.
2. Breastfeeding should begin as soon as possible after birth, usually within the first hour.⁸⁰⁻⁸² Except under special circumstances, the newborn infant should remain with the mother throughout the recovery period.^{80,83,84} Procedures that may interfere with breastfeeding or traumatize the infant should be avoided or minimized.
3. Newborns should be nursed whenever they show signs of hunger, such as increased alertness or activity, mouthing, or rooting.⁸⁵ Crying is a *late* indicator of hunger.⁸⁶ Newborns should be nursed approximately 8 to 12 times every 24 hours until satiety, usually 10 to 15 minutes on each breast.^{87,88} In the early weeks after birth, nondemanding babies should be aroused to feed if 4 hours have elapsed since the last nursing.^{89,90} Appropriate initiation of breastfeeding is facilitated by continuous rooming-in.⁹¹ Formal evaluation of breastfeeding performance should be undertaken by trained observers and fully documented in the record during the first 24 to 48 hours after delivery and again at the early follow-up visit, which should occur 48 to 72 hours after discharge. Maternal recording of the time of each breastfeeding and its duration, as well as voidings and stoolings during the early days of breastfeeding in the hospital and at home, greatly facilitates the evaluation process.
4. No supplements (water, glucose water, formula, and so forth) should be given to breastfeeding newborns unless a medical indication exists.⁹²⁻⁹⁵ With sound breastfeeding knowledge and practices, supplements rarely are needed. Supplements and pacifiers should be avoided whenever possible and, if used at all, only after breastfeeding is well established.⁹³⁻⁹⁸
5. When discharged <48 hours after delivery, all breastfeeding mothers and their newborns should be seen by a pediatrician or other knowledgeable health care practitioner when the newborn is 2 to 4 days of age. In addition to determination of

infant weight and general health assessment, breastfeeding should be observed and evaluated for evidence of successful breastfeeding behavior. The infant should be assessed for jaundice, adequate hydration, and age-appropriate elimination patterns (at least six urinations per day and three to four stools per day) by 5 to 7 days of age. All newborns should be seen by 1 month of age.⁹⁹

6. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth.¹⁰⁰ Infants weaned before 12 months of age should not receive cow's milk feedings but should receive iron-fortified infant formula.¹⁰¹ Gradual introduction of iron-enriched solid foods in the second half of the first year should complement the breast milk diet.^{102,103} It is recommended that breastfeeding continue for at least 12 months, and thereafter for as long as mutually desired.¹⁰⁴
7. In the first 6 months, water, juice, and other foods are generally unnecessary for breastfed infants.^{105,106} Vitamin D and iron may need to be given before 6 months of age in selected groups of infants (vitamin D for infants whose mothers are vitamin D-deficient or those infants not exposed to adequate sunlight; iron for those who have low iron stores or anemia).¹⁰⁷⁻¹⁰⁹ Fluoride should not be administered to infants during the first 6 months after birth, whether they are breast- or formula-fed. During the period from 6 months to 3 years of age, breastfed infants (and formula-fed infants) require fluoride supplementation only if the water supply is severely deficient in fluoride (<0.3 ppm).¹¹⁰
8. Should hospitalization of the breastfeeding mother or infant be necessary, every effort should be made to maintain breastfeeding, preferably directly, or by pumping the breasts and feeding expressed breast milk, if necessary.

ROLE OF PEDIATRICIANS IN PROMOTING AND PROTECTING BREASTFEEDING

To provide an optimal environment for breastfeeding, pediatricians should follow these recommendations:

1. Promote and support breastfeeding enthusiastically. In consideration of the extensive published evidence for improved outcomes in breastfed infants and their mothers, a strong position on behalf of breastfeeding is justified.
2. Become knowledgeable and skilled in both the physiology and the clinical management of breastfeeding.
3. Work collaboratively with the obstetric community to ensure that women receive adequate information throughout the perinatal period to make a fully informed decision about infant feeding. Pediatricians should also use opportunities to provide age-appropriate breastfeeding education to children and adults.
4. Promote hospital policies and procedures that facilitate breastfeeding. Electric breast pumps

and private lactation areas should be available to all breastfeeding mothers in the hospital, both on ambulatory and inpatient services. Pediatricians are encouraged to work actively toward eliminating hospital practices that discourage breastfeeding (eg, infant formula discharge packs and separation of mother and infant).

5. Become familiar with local breastfeeding resources (eg, Special Supplemental Nutrition Program for Women, Infants, and Children clinics, lactation educators and consultants, lay support groups, and breast pump rental stations) so that patients can be referred appropriately.¹¹¹ When specialized breastfeeding services are used, pediatricians need to clarify for patients their essential role as the infant's primary medical care taker. Effective communication among the various counselors who advise breastfeeding women is essential.
6. Encourage routine insurance coverage for necessary breastfeeding services and supplies, including breast pump rental and the time required by pediatricians and other licensed health care professionals to assess and manage breastfeeding.
7. Promote breastfeeding as a normal part of daily life, and encourage family and societal support for breastfeeding.
8. Develop and maintain effective communications and collaboration with other health care providers to ensure optimal breastfeeding education, support, and counsel for mother and infant.
9. Advise mothers to return to their physician for a thorough breast examination when breastfeeding is terminated.
10. Promote breastfeeding education as a routine component of medical school and residency education.
11. Encourage the media to portray breastfeeding as positive and the norm.
12. Encourage employers to provide appropriate facilities and adequate time in the workplace for breast-pumping.

CONCLUSION

Although economic, cultural, and political pressures often confound decisions about infant feeding, the AAP firmly adheres to the position that breastfeeding ensures the best possible health as well as the best developmental and psychosocial outcomes for the infant. Enthusiastic support and involvement of pediatricians in the promotion and practice of breastfeeding is essential to the achievement of optimal infant and child health, growth, and development.

WORK GROUP ON BREASTFEEDING, 1996 TO 1997
 Lawrence M. Gartner, MD, Chairperson
 Linda Sue Black, MD
 Antoinette P. Eaton, MD
 Ruth A. Lawrence, MD
 Audrey J. Naylor, MD, DrPH
 Marianne E. Neifert, MD
 Donna O'Hare, MD
 Richard J. Schanler, MD

LIAISON REPRESENTATIVES

Michael Georgieff, MD

Committee on Nutrition

Yvette Piovanetti, MD

Committee on Community Health Services

John Queenan, MD

American College of Obstetricians and
Gynecologists

REFERENCES

- Dewey KG, Heinig MJ, Nommsen-Rivers LA. Differences in morbidity between breast-fed and formula-fed infants. *J Pediatr*. 1995;126:696-702
- Howie PW, Forsyth JS, Ogston SA, et al. Protective effect of breast feeding against infection. *Br Med J*. 1990;300:11-16
- Kovar MG, Serdula MK, Marks JS, et al. Review of the epidemiologic evidence for an association between infant feeding and infant health. *Pediatrics*. 1984;74:S615-S638
- Popkin BM, Adair L, Akin JS, et al. Breast-feeding and diarrheal morbidity. *Pediatrics*. 1990;86:874-882
- Beaudry M, Dufour R, Marcoux S. Relation between infant feeding and infections during the first six months of life. *J Pediatr*. 1995;126:191-197
- Frank AL, Taber LH, Glezen WP, et al. Breast-feeding and respiratory virus infection. *Pediatrics*. 1982;70:239-245
- Wright AL, Holberg CJ, Martinez FD, et al. Breast feeding and lower respiratory tract illness in the first year of life. *Br Med J*. 1989;299:945-949
- Chen Y. Synergistic effect of passive smoking and artificial feeding on hospitalization for respiratory illness in early childhood. *Chest*. 1989;95:1004-1007
- Wright AL, Holberg CJ, Taussig LM, et al. Relationship of infant feeding to recurrent wheezing at age 6 years. *Arch Pediatr Adolesc Med*. 1995;149:758-763
- Saarinén UM. Prolonged breast feeding as prophylaxis for recurrent otitis media. *Acta Paediatr Scand*. 1982;71:567-571
- Duncan B, Ey J, Holberg CJ, et al. Exclusive breast-feeding for at least 4 months protects against otitis media. *Pediatrics*. 1993;91:867-872
- Owen MJ, Baldwin CD, Swank PR, et al. Relation of infant feeding practices, cigarette smoke exposure, and group child care to the onset and duration of otitis media with effusion in the first two years of life. *J Pediatr*. 1993;123:702-711
- Paradise JL, Elster BA, Tan L. Evidence in infants with cleft palate that breast milk protects against otitis media. *Pediatrics*. 1994;94:853-860
- Aniansson G, Alm B, Andersson B, et al. A prospective cohort study on breast-feeding and otitis media in Swedish infants. *Pediatr Infect Dis J*. 1994;13:183-188
- Cochi SL, Fleming DW, Hightower AW, et al. Primary invasive *Haemophilus influenzae* type b disease: a population-based assessment of risk factors. *J Pediatr*. 1986;108:887-896
- Takala AK, Eskola J, Palmgren J, et al. Risk factors of invasive *Haemophilus influenzae* type b disease among children in Finland. *J Pediatr*. 1989;115:694-701
- Istre GR, Conner JS, Broome CV, et al. Risk factors for primary invasive *Haemophilus influenzae* disease: increased risk from day care attendance and school-aged household members. *J Pediatr*. 1985;106:190-195
- Arnon SS. Breast feeding and toxigenic intestinal infections: missing links in crib death? *Rev Infect Dis*. 1984;6:S193-S201
- Pisacane A, Graziano L, Mazzarella G, et al. Breast-feeding and urinary tract infection. *J Pediatr*. 1992;120:87-89
- Lucas A, Cole TJ. Breast milk and neonatal necrotizing enterocolitis. *Lancet*. 1990;336:1519-1523
- Covert RF, Barman N, Domanico RS, et al. Prior enteral nutrition with human milk protects against intestinal perforation in infants who develop necrotizing enterocolitis. *Pediatr Res*. 1995;37:305A. Abstract
- Ford RPK, Taylor BJ, Mitchell EA, et al. Breastfeeding and the risk of sudden infant death syndrome. *Int J Epidemiol*. 1993;22:885-890
- Mitchell EA, Taylor BJ, Ford RPK, et al. Four modifiable and other major risk factors for cot death: the New Zealand study. *J Paediatr Child Health*. 1992;28:S3-S8
- Scragg LK, Mitchell EA, Tonkin SL, et al. Evaluation of the cot death prevention programme in South Auckland. *N Z Med J*. 1993;106:8-10
- Mayer EJ, Hamman RF, Gay EC, et al. Reduced risk of IDDM among breast-fed children. *Diabetes*. 1988;37:1625-1632
- Virtanen SM, Rasanen L, Aro A, et al. Infant feeding in Finnish children <7 yr of age with newly diagnosed IDDM. *Diabetes Care*. 1991;14:415-417
- Gerstein HC. Cow's milk exposure and type 1 diabetes mellitus. *Diabetes Care*. 1994;17:13-19
- Koletzko S, Sherman P, Corey M, et al. Role of infant feeding practices in development of Crohn's disease in childhood. *Br Med J*. 1989;298:1617-1618
- Rigas A, Rigas B, Glassman M, et al. Breast-feeding and maternal smoking in the etiology of Crohn's disease and ulcerative colitis in childhood. *Ann Epidemiol*. 1993;3:387-392
- Davis MK, Savitz DA, Graubard BI. Infant feeding and childhood cancer. *Lancet*. 1988;2:365-368
- Shu X-O, Clemens J, Zheng W, et al. Infant breastfeeding and the risk of childhood lymphoma and leukaemia. *Int J Epidemiol*. 1995;24:27-32
- Lucas A, Brooke OG, Morley R, et al. Early diet of preterm infants and development of allergic or atopic disease: randomised prospective study. *Br Med J*. 1990;300:837-840
- Halken S, Host A, Hansen LG, et al. Effect of an allergy prevention programme on incidence of atopic symptoms in infancy. *Ann Allergy*. 1992;47:545-553
- Saarinén UM, Kajosaari M. Breastfeeding as prophylaxis against atopic disease: prospective follow-up study until 17 years old. *Lancet*. 1995;346:1065-1069
- Udall JN, Dixon M, Newman AP, et al. Liver disease in α_1 -antitrypsin deficiency: retrospective analysis of the influence of early breast- vs bottle-feeding. *JAMA*. 1985;253:2679-2682
- Sveger T. Breast-feeding, α_1 -antitrypsin deficiency, and liver disease? *JAMA*. 1985;254:3036. Letter
- Greco L, Auricchio S, Mayer M, et al. Case control study on nutritional risk factors in celiac disease. *J Pediatr Gastroenterol Nutr*. 1988;7:395-399
- Morrow-Tlucak M, Haude RH, Ernhart CB. Breastfeeding and cognitive development in the first 2 years of life. *Soc Sci Med*. 1988;26:635-639
- Wang YS, Wu SY. The effect of exclusive breastfeeding on development and incidence of infection in infants. *J Hum Lactation*. 1996;12:27-30
- Chua S, Arulkumaran S, Lim I, et al. Influence of breastfeeding and nipple stimulation on postpartum uterine activity. *Br J Obstet Gynaecol*. 1994;101:804-805
- Dewey KG, Heinig MJ, Nommsen LA. Maternal weight-loss patterns during prolonged lactation. *Am J Clin Nutr*. 1993;58:162-166
- Kennedy KI, Visness CM. Contraceptive efficacy of lactational amenorrhoea. *Lancet*. 1992;339:227-230
- Gray RH, Campbell OM, Apelo R, et al. Risk of ovulation during lactation. *Lancet*. 1990;335:25-29
- Labbok MH, Colie C. Puerperium and breast-feeding. *Curr Opin Obstet Gynecol*. 1992;4:818-825
- Melton LJ, Bryant SC, Wahner HW, et al. Influence of breastfeeding and other reproductive factors on bone mass later in life. *Osteoporos Int*. 1993;3:76-83
- Cumming RG, Klineberg RJ. Breastfeeding and other reproductive factors and the risk of hip fractures in elderly woman. *Int J Epidemiol*. 1993;22:684-691
- Rosenblatt KA, Thomas DB, WHO Collaborative Study of Neoplasia and Steroid Contraceptives. *Int J Epidemiol*. 1993;22:192-197
- Newcomb PA, Storer BE, Longnecker MP, et al. Lactation and a reduced risk of premenopausal breast cancer. *N Engl J Med*. 1994;330:81-87
- Heck H, de Castro JM. The caloric demand of lactation does not alter spontaneous meal patterns, nutrient intakes, or moods of women. *Physiol Behav*. 1993;54:641-648
- Butte NF, Garza C, O'Brien Smith JE, et al. Effect of maternal diet and body composition on lactational performance. *Am J Clin Nutr*. 1984;39:296-306
- Montgomery D, Splett P. Economic benefit of breast-feeding infants enrolled in WIC. *J Am Diet Assoc*. 1997;97:379-385
- Tuttle CR, Dewey KG. Potential cost savings for Medi-Cal, AFDC, food stamps, and WIC programs associated with increasing breast-feeding among low-income Hispanic women in California. *J Am Diet Assoc*. 1996;96:885-890
- Wilson MH. Feeding the healthy child. In: Oski FA, DeAngelis CD, Feigin RD, et al., eds. *Principles and Practice of Pediatrics*. Philadelphia, PA: JB Lippincott; 1990:533-545
- Rohr FJ, Levy HL, Shih VE. Inborn errors of metabolism. In: Walker WA, Watkins JB, eds. *Nutrition in Pediatrics*. Boston, MA: Little, Brown; 1985:412
- American Academy of Pediatrics, Committee on Drugs. The transfer of drugs and other chemicals into human milk. *Pediatrics*. 1994;93:137-150
- American Academy of Pediatrics, Committee on Pediatric Aids. Human milk, breastfeeding, and transmission of human immunodeficiency virus. *Pediatrics*. 1994;93:151-153

- ciency virus in the United States. *Pediatrics*. 1995;96:977-979
57. Centers for Disease Control and Prevention. Recommendations for assisting in the prevention of perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus and acquired immunodeficiency syndrome. *MMWR*. 1985;34:721-732
58. World Health Organization. Consensus statement from the consultation on HIV transmission and breastfeeding. *J Hum Lactation*. 1992;8:173-174
59. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC: Government Printing Office; 1990: 379-380. US Dept of Health and Human Services publication PHS 91-50212
60. Ryan AS. The resurgence of breastfeeding in the United States. *Pediatrics*. 1997;99(4). URL: <http://www.pediatrics.org/cgi/content/full/99/4/e12>
61. Freed GL, McIntosh Jones T, Fraley JK. Attitudes and education of pediatric house staff concerning breast-feeding. *South Med J*. 1992;85:484-485
62. Freed GL, Clark SJ, Sorenson J, et al. National assessment of physicians' breast-feeding knowledge, attitudes, training, and experience. *JAMA*. 1995;273:472-476
63. Williams EL, Hammer LD. Breastfeeding attitudes and knowledge of pediatricians-in-training. *Am J Prev Med*. 1995;11:26-33
64. World Health Organization. *Protecting, Promoting and Supporting Breast-Feeding: The Special Role of Maternity Services*. Geneva, Switzerland: WHO; 1989:13-18
65. Powers NG, Naylor AJ, Wester RA. Hospital policies: crucial to breast-feeding success. *Semin Perinatol*. 1994;18:517-524
66. Braveman P, Egerter S, Pearl M, et al. Problems associated with early discharge of newborn infants. *Pediatrics*. 1995;96:716-726
67. Williams LR, Cooper MK. Nurse-managed postpartum home care. *J Obstet Gynecol Neonatal Nurs*. 1993;22:25-31
68. Gielen AC, Faden RR, O'Campo P, et al. Maternal employment during the early postpartum period: effects on initiation and continuation of breast-feeding. *Pediatrics*. 1991;87:298-305
69. Ryan AS, Martinez GA. Breast-feeding and the working mother: a profile. *Pediatrics*. 1989;83:524-531
70. Frederick IB, Auerback KG. Maternal-infant separation and breast-feeding: the return to work or school. *J Reprod Med*. 1985;30:523-526
71. Spisak S, Gross SS. Second Followup Report: *The Surgeon General's Workshop on Breastfeeding and Human Lactation*. Washington, DC: National Center for Education in Maternal and Child Health; 1991
72. World Health Assembly. *International Code of Marketing of Breast-milk Substitutes. Resolution of the 34th World Health Assembly*. No. 34.22, Geneva, Switzerland: WHO; 1981
73. Howard CR, Howard FM, Weitzman ML. Infant formula distribution and advertising in pregnancy: a hospital survey. *Birth*. 1994;21:14-19
74. Howard FM, Howard CR, Weitzman ML. The physician as advertiser: the unintentional discouragement of breast-feeding. *Obstet Gynecol*. 1993;81:1048-1051
75. Gartner LM. Introduction. Gartner LM, ed. *Breastfeeding in the hospital*. *Semin Perinatol*. 1994;18:475
76. American Academy of Pediatrics, Committee on Nutrition. Nutritional needs of low-birth-weight infants. *Pediatrics*. 1985;75:976-986
77. American Dietetic Association. Position of the American Dietetic Association: promotion of breast feeding. *Am Diet Assoc Rep*. 1986;86:1580-1585
78. Schanler RJ, Hurst NM. Human milk for the hospitalized preterm infant. *Semin Perinatol*. 1994;18:476-486
79. Lemons P, Stuart M, Lemons JA. Breast-feeding the premature infant. *Clin Perinatol*. 1986;13:111-122
80. Righard L, Alade MO. Effect of delivery room routines on success of first breast-feed. *Lancet*. 1990;336:1105-1107
81. Widstrom AM, Wahlberg V, Matthiesen AS, et al. Short-term effects of early suckling and touch of the nipple on maternal behavior. *Early Hum Dev*. 1990;21:153-163
82. Van Den Bosch CA, Bullough CHW. Effect of early suckling on term neonates' core body temperature. *Ann Trop Paediatr*. 1990;10:347-353
83. Wiberg B, Humble K, de Chateau P. Long-term effect on mother-infant behavior of extra contact during the first hour post partum v follow-up at three years. *Scand J Soc Med*. 1989;17:181-191
84. Sosa R, Kennell JH, Klaus M, et al. The effect of early mother-infant contact on breast feeding, infection and growth. In: Lloyd JK, ed. *Breast-feeding and the Mother*. Amsterdam: Elsevier; 1976:179-193
85. Gunther M. Instinct and the nursing couple. *Lancet*. 1955;575-578
86. Anderson GC. Risk in mother-infant separation postbirth. *IMAGE: J Nurs Sch*. 1989;21:196-199
87. De Carvalho M, Klaus MH, Merkatz RB. Frequency of breast-feeding and serum bilirubin concentration. *Am J Dis Child*. 1982;136:737-738
88. De Carvalho M, Robertson S, Friedman A, et al. Effect of frequent breast-feeding on early milk production and infant weight gain. *Pediatrics*. 1983;72:307-311
89. Klaus MH. The frequency of suckling—neglected but essential ingredient of breast-feeding. *Obstet Gynecol Clin North Am*. 1987;14:623-633
90. Mohrbacher N, Stock J. *The Breastfeeding Answer Book*. Schaumburg, IL: La Leche League International; 1997:60
91. Procianny RS, Fernandes-Filho PH, Lazaro L, et al. The influence of rooming-in on breastfeeding. *J Trop Pediatr*. 1983;29:112-114
92. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*. 3rd ed. Washington, DC: ACOG, AAP; 1992:183
93. American Academy of Pediatrics, Committee on Nutrition. *Pediatric Nutrition Handbook*. 3rd ed. Elk Grove Village, IL: AAP; 1993:7
94. Shrago L. Glucose water supplementation of the breastfed infant during the first three days of life. *J Human Lactation*. 1987;3:82-86
95. Goldberg NM, Adams E. Supplementary water for breast-fed babies in a hot and dry climate—not really a necessity. *Arch Dis Child*. 1983;58:73-74
96. Righard L, Alade MO. Sucking technique and its effect on success of breastfeeding. *Birth*. 1992;19:185-189
97. Neifert M, Lawrence R, Seacat J. Nipple confusion: toward a formal definition. *J Pediatr*. 1995;126:S125-S129
98. Vitoria CG, Tomasi E, Olinto MTA, et al. Use of pacifiers and breast-feeding duration. *Lancet*. 1993;341:404-406
99. The American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine. Recommendations for preventive pediatric health care. *Pediatrics*. 1995;96:373
100. Ahn CH, MacLean WC. Growth of the exclusively breast-fed infant. *Am J Clin Nutr*. 1980;33:183-192
101. The American Academy of Pediatrics, Committee on Nutrition. The use of whole cow's milk in infancy. *Pediatrics*. 1992;89:1105-1109
102. Saarinen UM. Need for iron supplementation in infants on prolonged breast feeding. *J Pediatr*. 1978;93:177-180
103. Dallman PR. Progress in the prevention of iron deficiency in infants. *Acta Paediatr Scand Suppl*. 1990;365:28-37
104. Sugarman M, Kendall-Tackett KA. Weaning ages in a sample of American women who practice extended breastfeeding. *Clin Pediatr*. 1995;34:642-647
105. Ashraf RN, Jalil F, Aperia A, et al. Additional water is not needed for healthy breast-fed babies in a hot climate. *Acta Paediatr Scand*. 1993;82:1007-1011
106. Heinig MJ, Nommsen LA, Pearson, JM, et al. Intake and growth of breast-fed and formula-fed infants in relation to the timing of introduction of complementary foods: the Darling study. *Acta Paediatr Scand*. 1993;82:999-1006
107. American Academy of Pediatrics, Committee on Fetus and Newborn, and American College of Obstetricians and Gynecologists. Maternal and newborn nutrition. In: *Guidelines for Perinatal Care*. 4th ed. Washington, DC: ACOG, AAP; 1997
108. Pisacane A, De Visia B, Valiante A, et al. Iron status in breast-fed infants. *J Pediatr*. 1995;127:429-431
109. American Academy of Pediatrics, Committee on Nutrition. Vitamin and mineral supplement needs in normal children in the United States. *Pediatrics*. 1980;66:1015-1021
110. American Academy of Pediatrics, Committee on Nutrition. Fluoride supplementation for children: interim policy recommendations. *Pediatrics*. 1995;95:777
111. Freed GL, Clark SJ, Lohr JA, et al. Pediatrician involvement in breast-feeding promotion: a national study of residents and practitioners. *Pediatrics*. 1995;96:490-494

Resources

If you have any questions regarding this guide:

Inland Counties Regional Perinatal Programs of California
Loma Linda University Children's Hospital
11234 Anderson Street
Post Office Box 2000, Room 3348
Loma Linda, California 92354

Phone: (909) 824-4359
FAX: (909) 478-4167
E mail: cmelcher@ahs.llumc.edu

San Bernardino County Department of Public Health
WIC Breastfeeding Program
351 N. Mountain View Avenue
San Bernardino, California 92415

Phone: (909) 387-6315 or
(909) 387-6336

Wellstart International
Corporate Headquarters
4062 First Avenue
San Diego, California 92103-2045

Phone: (619) 295- 5192
FAX: (619) 294-7787
Breastfeeding Helpline: (619) 295-5193

These policies are available on the Internet [HTTP\WWW Breastfeeding.org](http://www.breastfeeding.org) Breastfeeding Coalition of the Inland Empire, model policies.

Regional Breastfeeding Coalitions in California

Northern California

Name of Coalition	Contact Person	Phone #	Fax #
Alameda County Breastfeeding Task Force	Lyn Diana, RD, MA	(510) 628-7798	(510) 628-7890
Bay Area & Coastal Counties WIC Regional Network (Alameda, Contra Costa, Marin, Monterey, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano Counties)	Anne Garrett, RN, IBCLE	(650) 573-2955	(650) 577-9223
Breastfeeding Advisory Committee for San Mateo County WIC	Anne Garrett	(650) 573-2955	(650) 577-9223
Breastfeeding Coalition of Greater Sacramento	Janet Hill, RD, CLE	(916) 427-1134	(916) 395-7314
Breastfeeding Council of Tehama County	Sue Mitchell, RD	(916) 527-8791	(916) 527-6150
Breastfeeding Task Force of Humboldt County	Ninon McCullough, RN	(707) 445-6210	(707) 441-5686
Breastfeeding Task Force of Solono County	Teri Broadhurst, MPH, RD, CLC	(707) 435-2212	(707) 435-2217
Contra Costa Breastfeeding Task Force	Nancy Hill, MS, RD, CLE	(925) 313-6260	(925) 313-6708
El Dorado County Breastfeeding Task Force	Betsy Tapper	(530) 573-3383	
The Oroville Community Coalition for Breastfeeding	Debbie Pierce, RN, PHN	(916) 891-2869	(916) 891-8743
Northern California Breastfeeding Coalition (Santa Rosa)	Margaret Bregger	(707) 544-4506 Est. 739	(707) 526-1016
San Francisco Breastfeeding Promotion Coalition	Elaine Jewell	(415) 822-1406	
Santa Clara Valley Breastfeeding Task Force	Kathy Sweeney, RD, CLE	(408) 299-7004	(408) 287-9793
Santa Cruz County Breastfeeding Coalition	Robertta Barnett, RN, MS	(408) 454-4772	(408) 454-4982
Shasta County Breastfeeding Coalition	Susan Ann Spencer, IBCLC, CCE	(530) 245-6466	(530) 225-5722
Siskiyou County Breastfeeding Task Force	Patty Leal, RN, PHN, CLE	(916) 842-8242	(916) 841-0424
Yuba/Sutter Breastfeeding Task Force	Kathy Ang, RD	(916) 742-4993	(916) 742-2599

For a complete listing of Regional Breastfeeding Coalitions in California with addresses, contact www.breastfeeding.org

Regional Breastfeeding Coalitions in California, Continued

Central California

Name of Coalition	Contact Person	Phone #	Fax #
The Breastfeeding Coalition of Stanislaus County	Duster Harris, PHN	(209) 558-6815	(209) 558-8315
	or Monica Denofra	(209) 558-7377	(209) 558-7508
Central California WIC Breastfeeding Coalition	Julie Casillas, RD, CLE	(559) 263-1380	(559) 263-1152
Kern County Breastfeeding Promotion Coalition	Linda Erb	(805) 868-0523	(805) 868-0225
Kings County Breastfeeding Coalition	Gloria Pierson, PHN	(559) 582-2795	(559) 582-0927
	or Suzy Hendrickson, CLE	(559) 582-0180	(559) 582-0927
Inyo-Mono Counties: Breastfeeding is Best (group)	Carolyn Balliet	(760) 934-5410	(760) 924-5467
Modoc County Breastfeeding Coalition	Joyce Miller RN, PHN, CLC	(530) 233-6311	(530) 233-5754
Breastfeeding Coalition of San Joaquin County; A subcommittee of the Healthier Community Coalition	Kay Ruhstaller, RD	(209) 472-7093	(209) 472-9802

Southern California

Name of Coalition	Contact Person	Phone #	Fax #
Antelope Valley Breastfeeding Coalition	Sonja Beck, CLE	(661) 726-6441	
The Breastfeeding Task Force of Greater Los Angeles	Kiran Saluja, MPH, RD	(626) 856-6650	(626) 813-9390
Breastfeeding Coalition of San Luis Obispo	Christine Bisson, RD, CLE	(805) 781-5151	(805) 781-1217
North Santa Barbara (Santa Maria) Breastfeeding Coalition	Wrennette Hole, RD, CLE	(805) 346-8450	(805) 346-8243
Orange County Breastfeeding Coalition	Laurence Obaid, MS, RD, CLE	(714) 834-7986	(714) 834-8028
San Bernardino and Riverside Counties' Breastfeeding Coalition of the Inland Empire	Carol Melcher, RNC, MPH, CLE	(909) 824-4359 Ext 2	(909) 478-4167
San Diego County Breastfeeding Coalition	Jo Ann Shaw, RD, IBCCLC	(619) 505-3071	(619) 569-7906
South Santa Barbara Breastfeeding Coalition	Meg Beard, MPH, CHES, RD, CLE	(805) 681-5276	(805) 569-7875
Ventura County Breastfeeding Coalition	Margie Wilcox Rose, RD, MPH, IBCCLC	(805) 652-3214	(805) 652-5921
WIC Consortium of Southern California	Kiran Saluja, MPH, RD	(626) 856-6650	(626) 813-9390

For a complete listing of Regional Breastfeeding Coalitions in California with addresses, contact www.breastfeeding.org